

The State of New Hampshire Medical Surge Guideline

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INTRODUCTION

The Constitution of the State of New Hampshire mandates that every town and city responsible for the well-being and public health of their citizens. Regional and State agencies have been created to assist local government in fulfill this mandate.

The New Hampshire Department of Health and Human Services (NH DHHS) has been working for several years in collaboration with other state agencies in developing specific guidelines and policies for the prevention ad management of Public Health Emergencies. NH DHHS is the State agency responsible to provide technical assistance and guidance to the local communities to achieve those obligations. One of the goals within the mandate is to be fully prepared to prevent and properly respond to emergencies. Within the overall State response to any emergency, NH DHHS is the coordinator of the Emergency Support function 8 (ESF-8). In order to fulfill that role, the NH DHHS developed the NH Public Health Emergency and Response Plan. A key component of this plan is addressing medical surge needs. This document is the NH DHHS' technical proposal for how to prepare and respond to situations that challenge medical resources at the local, regional or State level.

In response to federal funding from the U.S. Centers for Disease Control and Prevention awarded to the states during 2006, the NH DHHS convened a Pandemic Preparedness Coordinating Committee (PPCC). PPCC members include elected and appointed public officials, representatives from professional associations representing first responders and health care providers, the National Guard, the business community, and other stakeholders. NH DHHS proposed to the PPCC that funding to support regional public health and pandemic planning efforts be distributed to regions to be known as All Hazards Regions (AHR). Attendees at a March 27, 2006 meeting of the PPCC unanimously supported the proposal to implement and fund AHR planning.

DHHS then issued a map of proposed AHRs (see attachment H) for consideration by Regional Coordinating Committees (RCC), which had been formed to oversee the planning efforts. RCCs were also charged with proposing changes in the alignment of the proposed AHRs and overseeing a process for municipalities to demonstrate their commitment to the AHR process by signing a Memorandum of Understanding (MOU) with AHR representatives. The final determination of each AHR was based on these MOUs. These RCC coordinate the development and implementation of all Public Health Emergency Planning in each AHR in New Hampshire.

I. Purpose

The State of New Hampshire Medical Surge Guideline describes the medical surge capacity and capability and provides guidance for medical surge planning in New Hampshire. The intent of this plan is to be prepared for emergencies that generate victims requiring medical treatment that surpass the normal resource capacity and/or capabilities of the State of New Hampshire.

Three distinct situations must be considered when planning for medical surge:

1. A widespread and prolonged emergency, such as a pandemic influenza. Normal medical capacity and/or capability in New Hampshire would be overwhelmed, and the ability to transfer victims within and out of the State would be extremely limited.
2. A localized emergency that overwhelms the ability of a local medical community to respond in a timely and appropriate manner. Victims could be evacuated to other locations or additional staff and supplies could be brought into the region to handle the surge.
3. An emergency occurring in a nearby metropolitan area. Emergencies occurring in nearby population centers, such as Boston or Worcester, may drive both ill and worried well into New Hampshire, taxing medical resources.

All three of these situations require communities to prepare locally and regionally for medical surge capacity and are therefore addressed in this document.

II. Process

The State Epidemiologist, Dr José T. Montero, created a workgroup to develop the NH Medical Surge plan. The workgroup, chaired by Drs. Elizabeth Talbot and Robert Gougelet, with membership including Drs. Lisa Carlson and Barry Stern, Jody Schweitzer, Carole Totzkay-Sitar, James Skiba, Deborah Yeager, Curtis Metzger, and Reilly Lewis, developed the first draft of this document following a series of weekly meetings. Wherever possible and appropriate, the workgroup relied on already existing State and federal plans, documents, and tools to achieve a consistent regional approach. Technical information from the Northern New England Metropolitan Medical Response System (NNE MMRS) and New England Center for Emergency Preparedness (NECEP) was also utilized to prepare this guideline.

The content of the document also incorporates consensus from discussions that occurred outside of the workgroup with a variety of colleagues. These discussions included:

- Health Resources Services Administration (HRSA) Surge Capacity Regional Workgroup, Boston, June 29-30, 2006
- Agency for Healthcare Research and Quality (AHRQ) representatives.
- Multiple federal workgroups including HRSA, HHS, DHS.

This document was then presented to the State Epidemiologist and the New Hampshire Communicable Disease Epidemic Control Committee (CDECC). After the document was approved by CDECC, it was presented to the Director of Homeland Security and Emergency Management (HSEM), the Director of NH Division of Public Health Services (DPHS) and the Commissioner of the NH DHHS. The Commissioner approved this plan on October 25, 2006, with the understanding that this is a dynamic document that will be modified based on science and policies developed at the State and national level. This Medical Surge Guideline will be presented to the Governor and the Legislature to be reviewed and incorporated in legislation as appropriate.

III. Audience

The intended audience for this document includes, but is not limited to: State government agencies and officials, local government agencies and officials, AHR groups, healthcare administrators and providers, and Emergency Support Functions #6 (Mass Care) and #8 (Health and Medical Services partners).

IV. Assumptions

- This document will be updated based on new information, especially following the release of the *Department of Homeland Security (DHS) Target Capabilities List (TCL)* and forthcoming surge capacity guidance from HRSA.
- This Medical Surge Guideline will coordinate with and complement existing State readiness initiatives including, but not limited to:
 - *The New Hampshire Public Health Emergency Preparedness and Response Plan.*
 - *Influenza Pandemic Public Health Preparedness and Response Plan.*
 - The Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP).
 - Other State emergency plans and essential support functions.
- There are many documents referenced in this document, indicated by *italics*. Please refer to the reference section for information on where these documents are available.
- This document is intended to guide preparation for diverse emergencies and therefore an all-hazards planning process was used, with incident-specific annexes.
- Planners should assume that traditional healthcare facilities, specifically acute care hospitals will be full, if not over, capacity.
- This document is National Incident Management System (NIMS) and National Response Plan (NRP) compliant.

V. Definitions

Please note that the following definitions were selected by the NH Medical Surge Workgroup, but may occasionally deviate from other documents, including other state planning documents.

Acute Care Center

An acute care center (ACC) is a facility established to provide medical care in a community-based location. ACCs are community-based healthcare surge facilities that provide limited care to patients that would normally require admission to an acute care hospital. ACCs are ideally located in buildings of opportunity in close proximity to an acute care hospital. ACCs will not manage critical care patients, such as victims requiring artificial ventilation.

Acuity

The severity of a patient's illness and the level of attention or service the patient will need from professional staff.

All-Hazard Regions (AHRs)

The New Hampshire Department of Health and Human Services and the Pandemic Planning Coordinating Committee divided the State of New Hampshire into 19 geographical regions for the purpose of all-hazards emergency planning. The regions are largely consistent with hospital service areas but may deviate based on healthcare delivery systems, economic ties, school systems, and daily living patterns of residents.

Alternative Care Facilities

A facility (usually associated with a hospital) that normally provides medical care that, during an emergency necessitating surge, could provide additional volume or type of medical care. This may include nursing home/ long-term care facilities or ambulatory medical clinics.

Buildings of Opportunity

Large facilities that are not normally used for healthcare services but have the basic utilities needed to support medical functions. Buildings of opportunity ideally but do not necessarily have internal systems to handle medical oxygen and vacuum capability. Facilities commonly designated as buildings of opportunity include schools, gymnasiums, and armories. The Agency for Healthcare Research and Quality (AHRQ) has published a tool to assist planners in ranking the suitability of buildings of opportunity. It is available in HTML format at http://www.AHRQ.gov/research/altsites/altmatrix1_final.htm or Microsoft Excel format at <http://www.AHRQ.gov/downloads/pub/biotertools/alttool.xls>.

Capability

The ability to appropriately use physical and human resources.

Capacity

Physical and human resources.

Hospital Surge Capability

Refers to the ability of hospitals to efficiently and appropriately use the physical and human resources necessary to meet an increased demand for medical care. In this document, hospital surge capability is described in Tier 1.

Hospital Surge Capacity

Refers to the quantifiable amount of hospital resources and services (i.e., staff, equipment and space) available to meet an increased demand for medical care. In this document, hospital surge capacity is also described in Tier 1.

Isolation and Quarantine

Isolation is the separation of an ill person from well persons. Quarantine is the separation of a well person who has been exposed to a contagious disease and may be incubating that contagious disease from well, unexposed persons. Both isolation and quarantine are for the purpose of preventing disease transmission.

Medical Command and Control (MCC)

Medical Command and Control should be assumed by a single hospital within an affected area. In New Hampshire, most AHRs only have a single hospital, which therefore would be the

designated MCC for an incident. If AHRs where there are multiple hospitals, a single hospital should be designated by the AHR during the planning process. The purpose of the MCC is to provide medical command and control, administrative assistance, technical supervision, and consultation services in support of health and medical response operations during times of emergency conditions.

Medical Surge Capability

Defined as the ability of an affected community or region to appropriately use physical and human resources in emergencies that overwhelm the normal medical infrastructure. It entails augmenting both non-ambulatory and ambulatory care.

Medical Surge Capacity

Defined as the quantifiable amount of community or regional resources and services available for providing medical care in emergencies that overwhelm the normal medical infrastructure (through numbers or types of patients or loss of infrastructure). Medical surge capacity encompasses both hospital and community-based surge capacity efforts and, as such, entails augmenting both non-ambulatory and ambulatory care. Medical Surge capacity needs to be determined in real time via technical information systems that can accurately assess the resources available and resource needs during that period of time.

Modular Emergency Medical System

The Modular Emergency Medical System (MEMS) is a conceptual framework for managing a surge in patients requiring triage, prophylaxis, or inpatient care (figure 1). Components of the MEMS associated with managing these needs are the Neighborhood Emergency Help Center (NEHC) and the Acute Care Center (ACC). In addition to these two functional operations, MEMS also describes the need for Medical Command and Control (MCC), development of a Casualty Transportation System (CTS), community outreach efforts, mass prophylaxis planning, and a public information campaign. Additional description of this system can be found at: http://www.nnemms.org/documents/Modular_Emergency_Medical_System_-_Expanding_Local_Healthcare_Structure_In_a_Mass_Casualty_Terrorism_Incident.pdf.

Neighborhood Emergency Help Center

Primarily, the Neighborhood Emergency Help Center (NEHC) is defined by Edgewood Chemical and Biologic Command, and intended to

- Function as a high volume point of dispensing (POD) for prophylactic medication
- Self-help information
- Instruction (e.g., home care, medical follow-up)
- Triage large numbers of people seeking care, especially to identify those that require inpatient care and to ensure that they are stabilized for evacuation to either an ACC or hospital, depending on the patient's level of acuity.

During a contagious event, clustering of well patients and ill patients is not recommended, and therefore a POD and a triage center cannot be located in the same building.

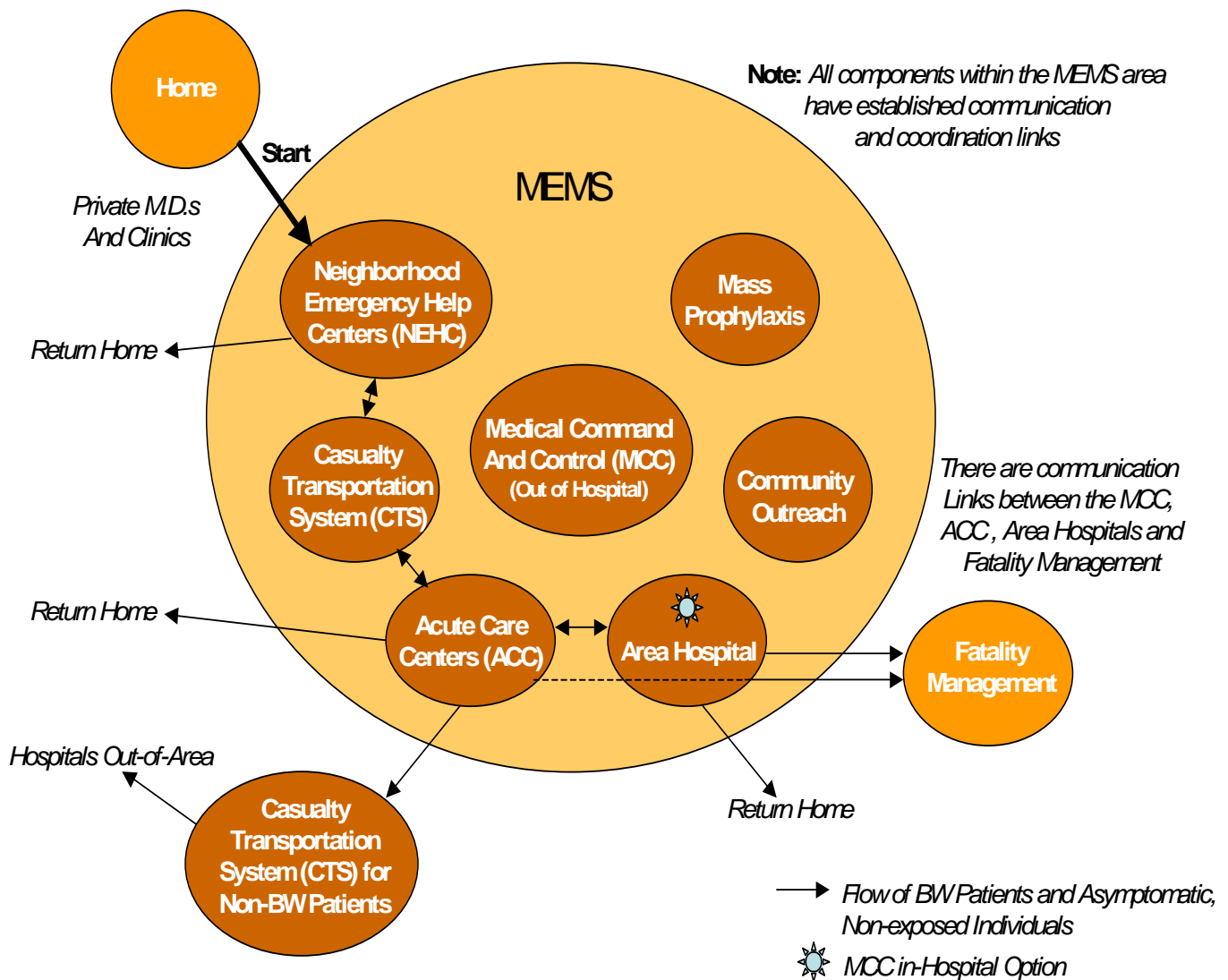


Figure 1. **The Modular Emergency Medical System.**

Point of Dispensing (POD)

Local facilities or sites that have been pre-designated to receive and distribute Strategic National Stockpile (SNS) supplies. The goal of the POD is to quickly dispense pills or administer shots to relatively healthy individuals and decrease the numbers of individuals who may get ill.

Response Tiers

The Medical Surge Capacity and Capability (MSCC) Management System published by the CNA Corporation for the U.S. Department of Health and Human Services in 2004 describes a management methodology based on principles of emergency management and the National

Incident Management System (NIMS). New Hampshire has adopted this tier system for providing structure to this guidance and outlining responsibility among the response agencies.

- **Individual Healthcare Assets (Tier 1)**

Tier 1 of surge capacity planning involves the individual healthcare facility planning to manage and recover from a surge of patients due to an emergency. This includes all types of medical care, ambulatory care provided by physicians, care provided by long-term care facilities, and acute care provided by hospitals. Beyond this, it is also the individual facility's responsibility to have support systems in place through preparedness to integrate surge capacity at their facilities with other healthcare facilities (Tier 2) and community medical surge capacity (Tier 3). Community medical surge capacity supports and augments hospital surge capacity through the development and implementation of additional resources to care for patients in settings other than the acute care hospital.

- **Healthcare Coalition (Tier 2)**

Tier 2 is defined as coordination among healthcare assets that serve a critical role in providing adequate and consistent care across an affected jurisdiction (i.e., local, regional or Statewide). The healthcare coalition provides a central integration mechanism for information sharing and management coordination among healthcare assets and establishes a balanced approach to integrating medical assets in the jurisdiction.

- **All Hazard Regions (AHR) (Tier 3)**

Tier 3 is defined as that community-wide medical surge capacity and capability created by the AHRs via a MCC. This planning occurs in the framework of a Modular Emergency Medical System (MEMS). ACCs, NEHCs, and coordination with primary medical providers are included in MEMS planning

- **State (Tier 4)**

Tier 4 is defined as State government leading medical emergency response across a range of AHRs depending upon the specific emergency. At this level the State provides support to emergencies managed at Tier 3.

- **Interstate (Tier 5)**

Tier 5 is medical emergency response coordinated between affected Border States and countries.

- **Federal Support to State and AHRs (Tier 6)**

Tier 6 refers to the State (Tier 4) and AHR (Tier 3) medical emergency response necessary to facilitate the request, receipt, and integration of federal health and medical resources to maximize medical surge capacity and capability.

VI. Authorities:

Authority for public health emergency preparedness planning and emergency response is outlined in Table 1.

Table 1. Statutory Authority

Statute	Agency	Authority
US Public Law 93-288	Federal government	Provides authority to respond to emergencies and provide assistance to protect public health; implemented by Federal Emergency Management Act
RSA 21-P: Department of Safety	Governor HSEM	Allows Governor to delegate authority to HSEM Director to carry out necessary functions to preserve lives of the people of NH during an emergency
RSA 4: Powers of the Governor and Council	Governor	Allows Governor to declare a state of emergency as that term is defined in RSA 21-P: 35, VIII Gives Governor direction and control of emergency management (see RSA 4:45, 4:46 & 4:47)
RSA 141-C: Communicable Disease	DHHS	Authorizes the DHHS to purchase and distribute pharmaceutical agents to prevent the acquisition and spread of communicable disease Authorizes the DHHS to adopt rules to distribute prescription pharmaceuticals in public clinics Establishes a vaccine purchase fund for the purchase of antitoxins, serums, vaccines and immunizing agents Allows DHHS to issue complaint to an individual and seek assistance of law enforcement; allows law enforcement officials to take an individual into custody and transport him/her to the place where he/she can be isolated, quarantined or treated; allows due process for such individuals (the right to a superior court hearing)
RSA 541-A: Administrative Procedure Act	State Agencies	Allows State agencies to adopt emergency rules when there is imminent peril to public health or safety, without going through normal rule making process; see also RSA 4:47, III which allows the Governor to make, amend, suspend or rescind orders, rules and regulations during a state of emergency
RSA 508:17-a	DHHS, DOS	Provides important protections for persons who are designated to act as agents of the State during a public health or public safety incident.

Local Authority

- All communities in the State, including those without existing health departments, are part of an AHR. The AHR have an RCC that oversees all Public Emergency Preparedness and response activities, under contract with the NH DHHS.

For further detail the *State of New Hampshire Public Health Emergency Preparedness and Response Plan* has a more detailed description of authority for public health emergency preparedness planning and emergency response. This plan can be found at: <http://www.dhhs.state.nh.us/DHHS/CDCS/LIBRARY/Policy-Guideline/dphs-health-emergency-plan.htm>

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VII. Surge Capacity Concepts Applicable Across All Tiers

Considerations for Planners at all Tiers

Planners should consider:

- Diverse population density, from dense urban areas to sparse rural areas
- The contiguous borders of Canada, Maine, Massachusetts, and Vermont
- The recent inclusion of the southern region of the State into the Boston Metropolitan Statistical Area (MSA) planning region. This underscores the need for New Hampshire to be prepared for a potential surge of evacuees, both sick and worried well, from urban centers including but not limited to Boston, Hartford, New York City, Springfield, and Worcester
- Seasonal population changes
- Special needs populations regarding medical surge. Another guidance document is forthcoming.

Medical Surge Capacity and Capability (MSCC)

New Hampshire has adopted the federal *MSCC Management System* and recommends public and private healthcare facilities and emergency planners also adopt the system. Deviations to the MSCC Management System are minimal and highlighted within this document.

Altered Standards of Care

During medical surge emergencies, there may be shortages of healthcare resources that will necessitate altered standards of care. The goal of an organized and coordinated response to a mass casualty event should be to maximize the number of lives saved. Changes in the usual standards of health and medical care in the affected region will be required to achieve the goal of saving the most lives in a mass casualty event. Rather than doing everything possible to save every life, it will be necessary to allocate scarce resources in a different manner to save as many lives as possible. Protocols for triage (i.e., the sorting of victims into groups according to their need and resources available) need to be flexible enough to change as the size of a mass casualty event grows and will depend on both the nature of the event and the speed with which it occurs.

NH DHHS understanding and management of altered standards of care follows the national guidelines detailed in: Bioterrorism and Other Public Health Emergencies: Altered Standards of Care in Mass Casualty Events. Agency for Healthcare Research and Quality for the U.S. Department of Health and Human Services. www.ahrq.gov. April 2005.

Standards of health and medical care, broadly defined, address not only what care is given, but to whom, when, by whom, and under what circumstances or in what places. A comprehensive set of standards for health and medical care specifies the following:

- **What**—what types of interventions, clinical protocols, standing orders, and other specifications should be used in providing health and medical care?
- **To whom**—which individuals should receive health and medical care according to their condition or likelihood of response and recovery?
- **When**—with what urgency should health and medical care be provided?
- **By whom**—which individuals are certified and/or licensed to provide care within a defined scope of practice and other regulations?
- **Where**—what facility and system standards (pre-hospital, hospital, alternate care site, etc.) should be in place for the provision of health and medical care?

A number of important nonmedical issues that affect the delivery of health and medical care need to be addressed to ensure an effective response to a mass casualty event. They include:

- The authority to activate or sanction the use of altered standards of care under certain conditions.
- Legal issues related to liability, licensing, and intergovernmental or regional mutual aid agreements.

Triage efforts that will need to focus on maximizing the number of lives saved. Instead of treating the sickest or the most injured first, triage would focus on identifying and reserving immediate treatment for individuals who have a critical need for treatment and are likely to survive.

Needs of current patients, such as those recovering from surgery or in critical or intensive care units; the resources they use will become part of overall resource allocation. Elective procedures may have to be cancelled, and current inpatients may have to be discharged early or transferred to another setting. In addition, certain lifesaving efforts may have to be discontinued.

Usual scope of practice standards that will not apply. Nurses may function as physicians, and physicians may function outside their specialties. Credentialing of providers may be granted on an emergency or temporary basis. It may be necessary to grant permission to certain professionals on a temporary and emergency basis to function outside their legal scope of practice or above their level of training.

Equipment and supplies that will be rationed and used in ways consistent with achieving the ultimate goal of saving the most lives (e.g., disposable supplies may be reused).

Delays in hospital care due to backlogs of patients. Patients will be waiting for scarce resources, such as operating rooms, radiological suites, and laboratories.

Providers who may need to make treatment decisions based on clinical judgment. For example, if laboratory resources for testing or radiology resources for x-rays are exhausted, treatment based on physical exam, history, and clinical judgment will occur.

Current documentation standards that will be impossible to maintain. Providers may not have time to obtain informed consent or have access to the usual support systems to fully document the care provided, especially if the health care setting is damaged by the event. Minimally accepted levels of documentation of care provided to an individual may have to be established, both for purposes of patient care quality and as the basis for reimbursement from third-party payers.

An adequate legal framework for providing health and medical care in a mass casualty event would do the following:

- Include a designation of the authority to declare an emergency and implement temporary alterations in standards of care.
- Define the conditions for temporary modification of laws and regulations that govern medical care under normal conditions.
- Be flexible enough to accommodate the demands of events that vary in size and rapidity, such as an explosive or biological event.

It is important to establish clear authority to activate the use of altered standards of health and medical care. The following questions pertain:

- What circumstances will trigger a call for altered standards of care?
- Who is authorized to make that call, and at what level (site, community, region, State, or Federal) should the call be made?
- Under what legal statutory authority, should the call be made?
- Once the call is made, who assumes responsibility for directing emergency actions?
- What is the relationship of otherwise autonomous institutions to the incident management system?

Some of the Federal, State, and local laws and regulations that govern the delivery of health and medical care under normal conditions may need to be modified or enhanced in the case of a mass casualty event. Relevant laws include but are not limited to the following:

- Emergency Medical Treatment and Active Labor Act (EMTALA)
- Health Insurance Portability and Accountability Act (HIPAA)
- Federal Volunteer Protection Act
- Good Samaritan Law

Additional types of laws and regulations that relate to the delivery of health and medical care include:

- 80-hour work week rule for medical residents
- Occupational Safety and Health Administration and other workplace regulations
- Building codes and other facility standards
- Publicly funded health insurance laws (including Medicare, Medicaid, and the State Children's Health Insurance Program)
- Laws and regulations governing the use and licensure of drugs and devices

In a declared state of emergency, the State of NH has expectations that altered standards of care will be established. Be advised that the State of New Hampshire is investigating the medicolegal and ethical issues surrounding altering standards of care, but, time permitting, it is expected that any legal or policy changes proposed during this review, will be presented to the Legislature. Examples of products expected from State workgroups on these topics include:

- General draft orders requiring only a signature from the Commissioner of Health and/or Governor to rapidly facilitate the adoption of altered standards of care during a emergency situation
- Guidance regarding triage of mechanical ventilation during an epidemic of respiratory disease
- Prioritization of groups for receipt of limited resources
- Usual scope of practice
- Legal framework for altered standards of care

The State of New Hampshire is investigating the medicolegal and ethical issues surrounding altering standards of care.

Volunteers and Credentialing

An emergency situation may create the need for and/or result in a large numbers of volunteers. Sources of volunteers include:

- The Northern New England Metropolitan Medical Response System Medical Strike Team (NNE MMRS MST)
- A Medical Reserve Corps (MRC) unit
- Community-based volunteers from the NH ESAR-VHP
- Faith-based organizations
- Non-governmental agencies
- Retired or currently unemployed but qualified volunteer providers
- Expanded groups of providers, such as veterinarians, dentists and dental auxiliary providers, pharmacists, and health professional students
- Reallocating providers from nonemergency care and nonemergency sites to emergency response assignments (this will involve identifying skill sets of each practitioner group [e.g., paramedics, nurse midwives, etc.], so as to optimize reassignment potential)
- Creating and training a pool of nonmedical responders to support health and medical care operations
- Access to volunteers through the ESAR VHP database.

A data base of medical and non-medical volunteers created under the Emergency System for the Advance Registration of Volunteer Healthcare Professionals (ESAR-VHP) is a national initiative supported in each state to address the need for healthcare volunteers in emergencies. The State will continue to develop and advocate the use of ESAR-VHP for emergencies in the State (and across State lines, as warranted). Information and on-line applications can be found at: <https://nhlicenses.nh.gov/MyLicense%20VHP/>. The preferred method of volunteering is through formalized teams and other community or State organized efforts. MMRS Strike Team, CERT, MRC, Red Cross, BHRT, and local community efforts allows pre-credentialing and identification, training and exercising, and command and logistical support. Local hospitals, other healthcare entities, AHRs, ACCs, or municipalities may solicit the State ESAR-VHP for help to respond to a medical surge capacity emergency. Requests for volunteers through ESAR-VHP should be coordinated through the local EOC/Incident Command and the State (EOC). Hospitals and healthcare entities will work with their various regulatory bodies to remain in compliance with granting privileges in their institutions. When physicians and other medical professionals report to an ACC or requesting institution for duty, the credentialing and verification process will already be complete, and a temporary identification badge will have been issued. NH DHHS or EOC may request on its own behalf, or on behalf of a municipality or an institution, help from another state. The ESAR-VHP systems in other states will be coordinated with the NH ESAR-VHP; these requests shall be handled under the Emergency Management Assistant Compact or EMAC. The EMAC is a mutual aid compact that each New England state has signed which allows for the sharing of critical resources, including personnel, during the time of an emergency (<http://www.emacweb.org/>).

Information Technology

The State of New Hampshire Department of Safety, Homeland Security and Emergency Management owns WebEOC, Crisis Information Management Software. This software tool allows users to virtually manage an emergency in a fashion that is compliant with the National Incident Management System (NIMS). The most relevant feature of WebEOC for local surge capacity planning purposes is the ability to manage resources on a statewide level. It is highly recommended that AHRs and hospitals use this software. Technical training will be made available by HSEM. Emergency management officials should use it to regularly update available resources to facilitate efficient direction of resources. Hospitals should use WebEOC to track bed availability on a daily basis, in a fashion consistent with the Agency for Healthcare Research and Quality (AHRQ) guidelines. The Northern New England MMRS owns the Health Care Standard software, which can be utilized by each hospitals and ACC to assess bed capacity and critical resources.

Funding

The Commissioner of NH DHHS will present this plan to the New Hampshire Legislature, to request their support through policy development, which may include future funding appropriations. NH DHHS will also make efforts to seek funding from other resources.

The Pandemic Planning Coordinating Committee (PPCC) will review regularly the plans presented by the regions and it will approve funding, as appropriate within the guidelines of the grants awarded to the State by the federal government.

Liability

- Current approach in New Hampshire law on the topic of liability protection for persons assisting in public health and other emergencies in New Hampshire is explained in the Revised Statutes Annotated (RSAs), TITLE LII: ACTIONS, PROCESS, AND SERVICE OF PROCESS, CHAPTER 508: LIMITATION OF ACTIONS, (see especially sections 12 and 17- <http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-LII-508.htm>). (Refer to Appendix E)
- Refer to Appendix F for changes in HIPAA Privacy during an emergency.
- Additional legislation will be introduced in the 2006-2007 legislative season.

VIII. Tier 1 – Surge Capacity of Individual Healthcare Assets

Hospitals will handle surge capacity by quickly maximizing their resources, integrating surge capacity at their facilities with other healthcare facilities. Refer to the *New Hampshire Hospital Surge Capacity and Capability Guideline* for detail.

Tier 1 also includes physician practices, visiting nurse associations, and long-term care facilities. These Tier 1 organizations need to be made aware of the larger community planning efforts and to be asked to develop their own individual emergency response plans. For example, a physician practice should make a reasonable effort to maintain a list of patients who might be especially susceptible to certain conditions (such as influenza) and/or who might be of special needs (e.g., homebound or limited-English proficiency patients). It is anticipated that such lists of patients may be used by either the medical provider or by public health authorities in a time of crisis to assist those individuals.

Also, there is a definite need for physicians' practices to identify mechanisms by which they would handle a sudden surge of patients calling and requesting appointments. Visiting nurse organizations' emergency planning should consider internal alterations in their usual standards of follow-up. For example, in a public health emergency, the number of visits performed for routine bandage checks may be altered, and the families may become more involved in the care of the patients. Nursing homes need to delineate plans for early discharges if needed in order to accommodate large influxes of patients.

All individual healthcare organizations need identify their key staff members, perform cross training for essential functions, and look at the availability of equipment and supplies in times of medical emergencies. Moreover, all healthcare organizations need to have infection control plans and emergency plans in place with a person designated as responsible for reviewing them on at least an annual basis.

IX. Tier 2 – Healthcare Coalition

Corporate Alliances

NH hospitals that are part of the same corporation and plan together to support each other on a small scale or singular internal emergency should ensure they still adhere to the Mutual Aid Network (see below) and AHRs.

Urban/Community/Regional/Coalitions

Jurisdictions that have more than one hospital, such as Manchester and Nashua, should ensure that all hospitals are part of urban planning groups and that preparedness and response is coordinated within their cities. Because most emergencies that would impact one hospital would impact others in the area, it is also prudent for hospitals in a region to plan together. For example, the Seacoast hospitals (5 independent facilities) collaborate on such operational functions as diversion.

The New Hampshire Hospital Mutual Aid Network

NH hospitals should continue to be signatories of the memorandum of understanding (MOU) that allows for hospital-to-hospital assistance on a statewide basis in the event of an emergency. The MOU addresses personnel, equipment and service support and signatories form the NH Hospital Mutual Aid Network.

Coordination of the Healthcare Coalition

Because relationships are built through planning together, New Hampshire Hospital Association (NHHA) is a practical facilitator and a knowledgeable resource for both the hospitals and the State. The NHHA will continue to coordinate preparedness through the Hospital Emergency Preparedness Group that is comprised of:

- Emergency preparedness coordinators
- Emergency Department (ED) directors
- ED physicians and nurses
- EMS coordinators
- Infection control practitioners
- NH Department of Health and Human Services
- NH Department of Safety
- State HazMat Teams
- Public Health Agencies

Hospitals will circulate plans on hospital preparedness issues, share best practices, emergency response planning strategies and lessons learned, federal requirements and progress, and updates

on State preparedness activities. Through the NH Hospital Mutual Aid Network, hospitals will engage in cooperative planning, information sharing and management coordination.

In an emergency, when the hospitals have reached capacity, they may first attempt to obtain support from other hospitals. In an emergency large enough to impact multiple hospitals in multiple areas, at the request of the NH-DHHS, NHHA could coordinate information flow, resource needs, and response activities between hospitals and the State. Such activities could include:

- Assisting in properly allocating equipment and supplies
- Augmenting personnel in collaboration with the ESAR-VHP
- Tracking patient movement

As described in Tier 1, outpatient medical care (ambulatory and non-ambulatory) also represents a critical resource that would be stressed in a public health emergency. Efforts must be made by the affiliated hospitals to incorporate these providers/organizations into their emergency planning discussions since many resources are shared and expectations and responsibilities of all health providers need to be clarified. While this overlaps into Tier 3 planning, there are certain items that pertain to smaller groups. For example, if there is a specific group of physicians associated with a hospital, then that group of physicians should be kept regularly informed of emergency planning efforts at the hospital and AHR levels.

X. Tier 3 – All-Hazards Planning Region (AHR)

The NH-DHHS has adopted and endorses AHRs use of the Modular Emergency Medical System (MEMS) as proposed by the Northern New England MMRS to expand local medical capacity in the event of an emergency. Each AHR should incorporate representatives from all types of medical care in their planning. This means that ambulatory medicine providers, long-term care facilities, visiting nurses, and acute care hospitals should be included in the planning efforts described below.

Each AHR should be able to establish a Neighborhood Emergency Help Center and Casualty Transport System (CTS) in addition to the Acute Care Center beds described below. As noted in the MEMS guidance documents, it is essential that the AHRs designate the organization of these in advance of an emergency. This would be done through the MCC that needs to be established in each AHR. Local health departments and/ or AHR officials, should coordinate the operation of the Unified Medical Branch in conjunction with area hospitals and with local providers. NH DHHS will provide all necessary technical assistance to facilitate this process, including medical direction as needed.

In advance of an emergency, the designees to the MCC should meet and agree upon some basic operating procedures, including how and when establishing the community-wide surge centers, NEHCs and ACCs.

Acute Care Center (ACC) Model Development and maintenance of a 50-bed ACC capacity in each of the 19 AHRs will provide a surge capacity capability of 950 beds within the State for patients requiring minimal medical therapy. In addition to the 950 beds, areas of special focus

will be established in the Concord, Exeter, Manchester, Nashua, and Southeastern AHRs to include 1 surge bed for every 1,000 population (by 25-bed increments) as shown in Table 2. The 50-bed ACC capacity is the smallest surge capacity building block outlined in the SBCCOM guidance and serves as a baseline for building surge capacity in AHRs. An AHR may choose to plan or implement the ACC jointly with other AHRs. In this case, they still need to plan for 1 surge bed for every 1,000 population (by 25-bed increments).

Recommendations

1. Each AHR will build and maintain a capacity to surge 50 community-based beds using the ACC design. AHRs with greater than 75,000 residents, specifically Concord, Exeter, Manchester, Nashua, and Southeastern AHRs, will build and maintain a capacity based on the ratio of 1 community surge bed per 1,000 population by 25-bed increments. The Dover and Keene AHRs may consider planning for an additional 25 beds over the initial 50-bed increment as the 2005 population in these two AHRs approached 75,000. NH DHHS also recognizes that hazards may differ by region, and, therefore, these are the minimum standards expected for developing extra medical care capacity. AHRs can propose to NH DHHS plans for joint ACCs between regions. The same relation between beds and population should be maintained.
2. ACC and /or NEHC will be activated under two different scenarios:
 - If the Commissioner of NH DHHS, declares a local, regional or Statewide Public Health Incident
 - In response to a recommendation from the NH DHHS, through the EOC, when the Governor has issued a regional or Statewide emergency declaration
3. Depending the Epidemiology of the cause for the declaration of a Public Health Incident or a State of Emergency the ACC and/or NEHC will move into a build-up stage or to full operational status.
4. Upon activation the Commissioner of NH DHHS will appoint a lead person to coordinate all necessary actions to reach the readiness level or the full operational status. This person and the other members of the area command team, working under designation from the Commissioner of DHHS, will be covered for liability as explained in Appendix E.
5. The command staff of the AHR Emergency Operations Center/MCC has the authority and responsibility to open an ACC and/or NEHC, after it has been recommended by NH DHHS, and as part of ESF-8 actions. For the description of the area command recommendations for the ACC, refer to annex G
6. Demand need not exceed capacity in order to open an ACC and/or NEHC. If a medical emergency exceeds or is expected to exceed an AHR's capacity to care for all of the individuals anticipated to become ill, then it is appropriate for that AHR/MCC to open an ACC and/or NEHC, as recommended by NH DHHS and approved by the Governor.
7. It is expected that the general design and implementation plan for the ACC and for the NEHC will be the responsibility of the AHR/MCC and that acute care hospitals will have a limited, but essential, role in both the planning process and response. Table 3 displays the State's acute care hospitals and the corresponding AHR.

Table 2. Minimum Recommended ACC Bed Capacity Per 2005 Population by AHR

AHR	2005 Population*	ACC Bed Capacity
Bristol/Franklin Region	34,571	50
Claremont/New London Region	42,452	50
Concord Region	130,783	150
Conway Region	19,257	50
Dover Region	70,313	50 + 25 (optional)
Exeter Region	101,901	100
Great North Woods	33,655	50
Keene Region	65,438	50 + 25 (optional)
Laconia/Meredith Region	54,422	50
Lebanon/Hanover Region	45,112	50
Lisbon Region	21,801	50
Manchester Region	183,952	200
Nashua Region	207,861	200
Peterborough Region	37,799	50
Plymouth Region	18,685	50
Portsmouth Region	36,272	50
Rochester Region	48,702	50
Southeastern Region	135,119	150
Southern Carroll	21,846	50
Total	1,309,941	1500 + 50 (optional)

* Data is obtained from 2005 population estimates

8. Acute Care Hospitals as part of the MCC should provide medical oversight consistent with the *Regional Response System Planning Guide*.
9. Regions will need to include rehabilitation hospitals in the medical surge planning process, as applicable.
10. ACC and/or NEHC staff will come from existing healthcare volunteer resources, such as described above.

Hospitals must be engaged in the process; however, in order to maintain operations at the acute care hospital facilities, they cannot be the primary provider of the staffing for an ACC and/or NEHC. (Refer to the *State of New Hampshire Public Health Emergency Preparedness and Response Plan* Volunteerism section)

11. No payment from victims/patients shall be expected at the time of service. Withholding essential treatment due to patients' inability to pay is not acceptable under any circumstances. AHRs should plan to closely account for services provided, as any reimbursement would be retroactive in nature. The State is currently considering means by which to create an agreement with insurers to cover costs incurred during emergency situations.

Table 3. AHR and Corresponding Hospital

AHR	Hospital
Bristol/Franklin Region	Franklin Regional Hospital
Claremont/New London Region	New London Hospital and Valley Regional Hospital
Concord Region	Concord Hospital
Northern Carroll Region	Memorial Hospital
Dover Region	Wentworth Douglass Hospital
Exeter Region	Exeter Hospital
Great North Woods	Androscogin Valley Hospital, Upper Connecticut Valley Hospital, and Weeks Medical Center
Keene Region	Cheshire Medical Center
Laconia/Meredith Region	Lakes Region General Hospital
Lebanon/Hanover Region	Dartmouth Hitchcock Medical Center and Alice Peck Day Hospital
Lisbon Region	Littleton Hospital and Cottage Hospital
Manchester Region	Catholic Medical Center and Elliot Hospital
Nashua Region	Southern New Hampshire Medical Center and St. Joseph's Hospital
Peterborough Region	Monadnock Community Hospital
Plymouth Region	Speare Memorial Hospital
Portsmouth Region	Portsmouth Regional Hospital
Rochester Region	Frisbie Memorial Hospital
Southeastern Region	Parkland Medical Center
Southern Carroll	Huggins Hospital

12. AHR planning for both stockpiling and obtaining medical supplies during an emergency is essential. ACC and/or NEHC plans should include provisions for a minimum of 72 hours of self-sufficiency in all aspects of resources once an emergency has occurred.
13. Guidelines describing appropriate clinical and ethical practice in light of possible medication and equipment shortages will be expected from both the State and Federal Governments. The

command structure (i.e., MCC) within the Emergency Operations Center has the responsibility during an emergency to manage the distribution of resources within the ACCs and/or NEHCs in as equitable and efficient a manner as possible during the course of an emergency.

14. The State will request that the usual regulatory constraints placed on medical providers for accreditation during non-emergency situations be temporarily modified during community emergencies. This includes altering standards of care as well as modifying the application of the Emergency Medical Treatment and Active Labor Act (EMTALA).
 - EMTALA requires hospital emergency departments (EDs) to provide any individual coming to their premises with a medical screening exam to determine if an emergency condition or active pregnancy labor is present. If so, the hospital must supply either stabilization prior to transferring the patient or a certification (signed by the physician) that the transfer is appropriate and meets certain conditions.
15. Regional planners should construct a memorandum of agreement with their local medical gas company to supply medical grade oxygen (low flow) to an acute care center during an emergency situation.
16. Community sites may be multipurpose, depending upon the stage or type of emergency. (i.e. Buildings of Opportunity within AHR regions may also be designated as ACCs, NEHCs, PODs, or mass care shelter sites.)
17. The public will receive information from the local PIO in coordination with the State PIO directing them to report to the NEHC for triage rather than to hospitals if ill. Every effort shall be made by the MCCs to share this message with other ambulatory care providers in the AHR. Triage centers at the NEHC and/or the ACC will determine whether or not ill individuals need to be:
 - Transported to a hospital
 - Admitted to the ACC
 - Connected to support services if worried well
 - Return home

Acute Care Center Concept of Operations Within an AHR

As noted previously, the State of New Hampshire DHHS has adopted the Edgewood Chemical and Biological Command *Modular Emergency Medical System Guidance*. Consequently planners should consult this series of documents when developing their AHR plans. The following outline provides reference to the SBCCOM Guidance, New Hampshire relevant information, and exceptions.

1) Scope

a) Risk Management/Policy

Staff at ACCs and/or NEHCs, as well as any other volunteers within the community, activated and working under a Commissioner declared Public Health Incident or a

Governor declared State of Emergency would be covered as State employees for the purposes of liability and workers' compensation (See Appendix E).

b) Level of Care Philosophy

The ACC and/or NEHC are community-based healthcare surge facilities that provide care to patients normally requiring inpatient medical treatment but not requiring critical care. An ACC acts as a local facility for patients requiring minimal or noncomplex therapies and supportive therapy (i.e., antibiotic therapy, hydration, bronchodilators, and pain management). ACCs will not be designed to manage critical care patients, such as victims requiring artificial ventilation. The ACC is intended to free the acute care hospitals to focus on the treatment of critically ill patients. ACCs enhance hospital-based surge capacity efforts by reducing the volume of low acuity patients receiving treatment in an acute care hospital setting.

c) Standing Admission Orders

The New Hampshire DHHS will supply additional admission order templates in the future. Sample orders will be used and signed by the physicians at the ACCs. A series of sample admission orders is contained in Appendix A of the *Acute Care Center Concept of Operations* document.

2) Organization

a) Command Organization

Chapter 3.1 of the *Acute Care Center Concept of Operations* document details the need for integrating an ACC into the local emergency management incident command system/MCC.

b) Patient Flow

Chapter 3.2 of the *Acute Care Center Concept of Operations* document details a conceptual model for moving patients to an ACC within the larger MEMS model.

c) Facility Requirements

Chapter 3.3 of the *Acute Care Center Concept of Operations* document details the facility requirements for constructing an ACC. Additional information that may be helpful to planners has been developed by AHRQ, specifically, a web-based tool to evaluate buildings of opportunity for suitability as ACCs.

<http://www.AHRQ.gov/research/altsites/alttool1.htm>

d) Transportation

The Transportation Research Board (TRB) has addressed transporting victims to mass care facilities in "A Guide to Transportation's Role in Public Health Disasters." An Excel spreadsheet has also been prepared that can assist planners.

[http://www4.trb.org/trb/crp.nsf/reference/boilerplate/Attachments/\\$file/20-59\(19\)_TERET.xls](http://www4.trb.org/trb/crp.nsf/reference/boilerplate/Attachments/$file/20-59(19)_TERET.xls)

3) Staffing

The *SBCCOM / ECBC* document provides a baseline staffing framework for providing direct healthcare services to 50 patients in 12 hour shifts within an ACC. The Rocky Mountain

Bioterrorism (RMBT) Working Group recognized that the ACC model failed to consider additional staff that would be vital to sustain operations within an ACC and may not be directly participating in medical aspects of patient care. In addition to highlighting these providers, the RMBT workgroup recognized the diversity in staffing demands is dependent on the hazard as shown in Table 4.

These staffing figures were generated according to disease communicability. Consequently, these should only be viewed as a guide because specific diseases may require a larger number of specialized practitioners, and routine or stable illnesses may require fewer resources based on efficiency of care.

Table 4. Staffing Levels per 12-Hour Shift for 50 Bed ACC

Class	Contagious	Non-Contagious	Quarantine	Class	Contagious	Non-Contagious	Quarantine
Physician	1	1	0	Food Service	2	2	2
Physician extender (PA/NP)	1	1	0	Chaplain / Pastoral	1	1	1
RNs or RNs/LPNs	6	6	2	Day care / Pet care	0	0	1
Health technicians	4	6	1	Volunteers	4	4	4
Unit secretaries	2	2	1	Engineering / Maintenance	0.25	0.25	0
Respiratory Therapist	1	1	0	Biomed	0.25	0.25	0
Case Manager	1	1	0	Security	2	2	2
Social Worker	1	1	1	Patient transporters	2	2	0
Housekeepers	2	2	1	Medical Asst / Phlebotomy	1	1	0
Lab Personnel	1	1	0				

4) Operational Considerations

a) Extemporaneous Training

Chapter 5.1 of the *Acute Care Center Concept of Operations* document details the need for just in time training for facility volunteers.

b) Job Action Sheets

A robust series of job descriptions is available from Appendix D, Job Action Sheets, of the *Acute Care Center Concept of Operations* document.

c) Patient Records

A system intended to transfer or combine electronic medical records from a variety of sources during an emergency is under development. NH DHHS, in consultation with the PPCC Technology Subcommittee, will review and approve the system to be used by all AHRs. Until a system such as this is ready for widespread use, paper patient records are appropriate for use.

d) Patient Tracking

Currently there is limited federal guidance for the development of patient tracking systems. A pilot study is currently underway to develop software that will be capable of tracking initial patient contact, disposition, and possibly follow-up for disease surveillance purposes. In addition to this initiative, HC Standard, software developed by Global Emergency Resources (GER) in consultation with the NNE MMRS, has the ability to track community-based resources. GER is working towards incorporating patient tracking into HC Standard.

e) Medical Equipment and Supplies

i) Assess local and regional supplies and equipment

(1) In an emergency, the local EOC requests supplies through the State EOC

(a) A limited cache of supplies stored in trailers throughout the State of NH may be available on a first-come, first-serve basis through the State EOC.

f) Pharmacological and Therapeutic Drugs and Agents Recommended for ACC

Appendix F of the *Acute Care Center Concept of Operations* document details a recommended list of pharmaceuticals for use at an ACC. The New Hampshire DHHS will provide additional guidance as to the appropriate pharmaceuticals for use in an ACC. DHHS will develop policies to guide the AHRs purchase and storage of pharmaceuticals.

g) Environmental Health and Sanitation

Chapter 5.7 of the *Acute Care Center Concept of Operations* document details the need for adequate housekeeping staff to maintain an ACC for an extended period of time.

h) Personal Protection Measures

Chapter 5.8 of the *Acute Care Center Concept of Operations* document details the personal protection measures and equipment needed to perform standard (universal) precautions. Healthcare practitioners would use expanded precautions to protect themselves during a pandemic emergency. Additional guidance from the New Hampshire DHHS is available in Appendix 4 of the *Influenza Pandemic Public Health Preparedness and Response Plan*.

i) Provisions for Special/Functional Needs Individuals

Chapter 5.9 of the *Acute Care Center Concept of Operations* document details special considerations to be used when treating children or families.

The New Hampshire DHHS and HSEM recognize that there are residents of the State who will require additional assistance in an ACC. Additional guidance will be released by HSEM detailing ways for local planners to address these needs and access support services available from the State and non-governmental organizations.

j) Staff Support Services

Chapter 5.10 of the *Acute Care Center Concept of Operations* document details the needed staff support services in order to keep an ACC functioning for an extended time.

k) Epidemiologic and Public Health Investigation

Chapter 5.11 of the *Acute Care Center Concept of Operations* document details the Epidemiologic and Public Health Investigation needs during a bioterrorism emergency. Due to the unique public health structure in the State of New Hampshire, it is recommended that local planners review the *Public Health Emergency Preparedness Plan*. AHRs can expect to receive guidance from the State of NH, because surveillance needs will be incident specific.

l) Patient Disposition

Chapter 5.12 of the *Acute Care Center Concept of Operations* document details patient discharge from the ACC. This chapter highlights strategies for reducing ACC census such as by the discharge of patients capable of being managed in their home. Also covered in this chapter is the need for mass-fatality planning. AHRs will receive mass fatality guidance from the State.

m) Food Service

Chapter 5.13 of the *Acute Care Center Concept of Operations* document details the food requirements for both staff as well as patients of an ACC.

n) Hospice Care

Chapter 5.14 of the *Acute Care Center Concept of Operations* document details the need for the availability of robust hospice care in an ACC. Local planners should plan to provide hospice care in an ACC consistent with current standards of care. The State of New Hampshire will consider altered standards of care, and make recommendations to the AHRs.

Neighborhood Emergency Help Centers (NEHC) Concept of Operations within an AHR

The Neighborhood Emergency Help Center (NEHC) can serve three primary purposes:

- A community casualty collection point where victims can quickly enter the medical system, which serves to assess the incident, facilitate victim tracking, and direct casualties and “worried well” away from emergency departments (EDs), allowing hospitals to function.
- Site to render basic medical evaluation and triage, allowing medical providers to focus their efforts and make efficient use of finite resources.
- Provision of limited treatment for people seeking aid, including stabilization care and self-help information and instruction. However, the NEHC is not a point of dispensing for prophylaxis or medication.

There are two different approaches an AHR can take when designing their NEHC. AHRs need only choose one of the following two methods:

- The NEHC is attached to the ACC and will serve all three of the purposes listed above. The NEHC will triage and sort patients based upon need and available resources. Patients may go from the NEHC to the hospital, ACC, referred to behavioral health services, or sent home with self-care instructions.

-OR-

- The NEHC is located away from the ACC and hospital and only serves as an information station for self-help information and instruction. This center would need to provide a staffed 24-hour hotline for the public to call and obtain information. If an AHR chooses this approach, a triage center will need to be located at the ACC and have provisions for the worried well and self-care instruction.

NEHC/Triage Functional Areas

1) Operations Center.

This unit is responsible for the command, control, and administrative activities of the NEHC. This unit conducts the administrative records processing, periodic reporting and external communication, and coordinates patient evacuation and logistic support. The unit also develops and enforces the internal policies and staffing strategies to operate the center, consistent with the guidance provided by the Medical Command Center (MCC).

2) Initial Sorting Area.

This unit is responsible for issuing each patient a control number. The unit quickly assesses each patient as they enter the center, separating the critically ill and non-critical patients. This unit is responsible for identifying critically ill patients and transporting them to the Treatment and Stabilization Area.

3) Registration Area.

This unit is responsible for initiating the medical recording and victim tracking processes. The unit also provides a sheltered waiting area for patients prior to registration. The unit documents general patient information and establishes a patient record for all non-critical patients. Critical patients will be registered in the treatment areas.

4) Triage and First Aid Area.

This unit is responsible for continuing the triage process and providing first aid care. The unit conducts a simple clinical evaluation of all non-critical patients following registration and records initial assessment findings, treatment, and vital signs. Patients identified as needing care beyond first aid treatment are transferred to the Treatment and Stabilization Area.

5) Out-Processing Area.

This unit is responsible for providing an ample and expeditious clearing process. This unit provides mass patient education and counseling briefings and issues self-help information packets. The unit also collects patient records upon discharge.

6) Treatment and Stabilization Area.

This unit is responsible for conducting rapid patient assessment and providing initial stabilization treatment to critically ill patients. This unit provides reasonable life-saving intervention to stabilize patients for rehabilitation or transfer to a definitive care facility.

7) Observation and Holding Area.

This unit is responsible for continuing the initial stabilization care and monitoring the outcome of treatment until patients are cleared for discharge. This unit provides continuation of

the care initiated in the Treatment and Stabilization Area and provides an area to hold patients that require hospitalization until they are transported to a more acute setting.

8) Service Support Area.

This area accommodates the NEHC's multiple support activities, such as facility maintenance, housekeeping, equipment/supply storage, staff break area, and in certain cases, family services and counseling areas.

NEHC Operations

1) General.

NEHC is a community-based care center. Residents in the community are directed to the center via a coordinated public information effort.

2) Triage.

As above, the NEHC uses several stages of assessment, sorting, and triage throughout the process to prioritize and categorize patients for care. Overall, the NEHC will employ a triage protocol that strictly sorts patients into four categories.

- **Immediate (red tag).** Patients who need emergency life-saving treatment. These patients have priority for treatment and transportation to advanced care facilities. These patients will likely be admitted to a hospital or ACC following initial treatment and stabilization at the NEHC. Treatment for these individuals at the NEHC should be timely but should not over-consume resources or time.
- **Delayed (yellow tag).** Those who require limited medical intervention for stabilization and their condition permits some delay in therapy. These patients may eventually be admitted or discharged following temporary medical observation.
- **Minimal (green tag).** Patients who may or may not require treatment. These patients will most likely receive prepackaged pharmaceuticals and general self-help information and will be discharged or referred to their private physician.
- **Expectant (black tag).** Individuals who arrive deceased or are not likely to survive. Fatalities will be housed in the NEHC's temporary morgue facility.

3) Patient Flow.

Casualties arrive at the NEHC primarily by their own means and are directed to the Initial Sorting Area, where they are rapidly assessed and sorted by triage personnel into two groups. The first group is non-ambulatory patients, ambulatory patients requiring immediate care, and patients arriving deceased. Each patient in this group is issued a control number and is transported directly to the Treatment and Stabilization Area. The second group is non-critical ambulatory patients, who are issued a control number and directed to the NEHC's Registration Area. Following registration, the second group is reassessed and categorized at the Triage and First Aid Area where they receive a basic clinical assessment and first aid care, if needed. Patients not requiring care beyond self-help information are categorized "minimal" and directed to the Out-Processing Area. Patients sent to the Out-Processing Area are given an instructional briefing and discharged. Discharge includes collection of patient records and referral to psychological counseling or other human relief services. Patients identified as needing medical

care beyond first aid during Triage and First Aid are re-categorized “immediate” or “delayed” and forwarded to the Treatment and Stabilization Area.

As patients arrive at the Treatment and Stabilization Area, they are assessed head-to-toe and triaged prior to receiving care. The medical providers in this area will render initial stabilization and treatment in the order of priority assigned by triage. Patients categorized “immediate” are treated first; and “delayed” patients are treated next. Once “immediate” and “delayed” patients have been stabilized within the limitations of the NEHC capabilities, they are transferred to the Observation and Holding Area.

Arrangements are made to evacuate patients requiring in-patient care to a definitive care facility. In some instances, patients evacuated from the NEHC may not be clinically stable because of the severity of their condition, limited medical resources, and time constraints. Patients, whose condition allows, may be released from the Observation and Holding Area for out-processing.

“Expectant” patients are managed after “immediate” and “delayed” patients. Deceased patients are pronounced dead by a Stabilization Team and transferred to the center’s Temporary Morgue. Patients considered unsalvageable are categorized “expectant” and transferred to the Observation and Holding Area for monitoring until all patients assigned “immediate” priority have received care. All other patients transferred to the Observation and Holding Area will continue treatment under medical supervision.

4) Information Flow.

Individual patient information is captured on a patient record. This document should accompany patients throughout the NEHC process. The records of patients discharged home are collected as they out-process the center. These records should be maintained at the center and used to generate data critical to the epidemiological investigation effort of the response. The records of patients transferring to a hospital or ACC should accompany those individuals to the next level of care. Information from these records is used to initiate the receiving facility’s patient record as well as continue care. A patient tracking record should also be maintained for accountability purposes to record the arrival and departure of all patients presenting to the center.

The NEHC generates situation/status reports reflecting patient and staffing activity as well as material and personnel accountability. Emergency planners must pre-establish specific reporting processes. NEHCs must use standardized reporting forms and formats to facilitate the compilation and analysis of information from numerous centers. NH DHHS will supply these forms. Data from these reports is used to make operational decisions on medical logistical support, mobilization, and demobilization operations.

5) Response Integration and Interoperability.

Once established, the NEHC does not function as a stand-alone operation. Integration with medical evacuation (e.g., Casualty Transportation), in-patient care (e.g., hospitals or ACCs), community outreach, and the medical logistic systems are critical. The NEHC must coordinate with appropriate command elements to ensure timely and seamless patient flow and to sustain

operations. The NEHC is not a definitive care facility; therefore, emergency medical planners must coordinate preregistration of patients to receiving in-patient care facilities.

NEHC resources and documents are available in the appendices of the:

Wall, W.T., Dragunas, G.A., Blackman, E., and Catlett, M. Modular Emergency Medical System: Concept of Operations for the (NEHC)- Mass Casualty Care Strategy for a Biological Terrorism Incident. November 2002

This document is available at the following link: <http://www.nnemmr.org/surge.html>

State Responsibilities

- Funding
 - State General Funds specifically appropriated by the NH Legislature
 - Centers for Disease Control and Prevention categorical grants
 - Pandemic Influenza preparedness grants from the federal government
- Guidance
 - Memorandum of Understanding: The State must participate in the Signing of Memorandum of Understanding (MOU) with each AHR detailing responsible parties for the critical components needed to establish first a MCC and then an ACC and/or NEHC during an emergency situation.
 - Altered Standards of Care: The State must provide guidance to the AHRs describing the level of care expected of healthcare providers working in an ACC and/or NEHC environment. Legislation to facilitate this process will be discussed during the 2006-2007 legislative season.
 - Expanded Scope of Practice: It is the State of New Hampshire's responsibility to identify, credential, and facilitate the use of healthcare practitioners who do not normally hold a license within the State. Furthermore, it is the responsibility of the State to identify what types of practitioners could operate with an expanded scope of practice and at what times. These decisions involve licensing and certification processes that can only be handled at the State level.
 - Clinical guidance for prophylaxis administration, when available.

AHR Responsibilities

- Adopt the SBCCOM Model for NEHCs and ACCs at the following website:
<http://www.nnemmr.org/surge.html>
 - Refer to table 2 to determine the number of beds to be planned for in your ACC.
 - Refer to Appendix D for pandemic influenza assumptions by AHR.

- Go to the following website to obtain facility requirements:
<http://www.AHRQ.gov/research/altsites/alttool1.htm>
 - Investigate buildings of opportunity in your AHR.
 - Each of the 19 AHRs is required to perform an assessment of potential assets to be used for medical surge capacity during a mass casualty response. Ideally, these assets will be located in buildings of opportunity that are in close proximity to an existing acute care hospital. AHRs shall identify and document in an organized and consistent manner space within their region that may be used for this purpose. Each facility will have a document plan outlining operational procedures, activation, notification, and staffing. In addition, a draft MOU will be constructed by HSEM between the AHR and the facility guaranteeing its availability during an emergency.
 - In some communities there may be larger venues that are capable of holding more than 50 patients. These facilities could include arenas, coliseums, or field houses. If AHRs intend on designating these facilities as ACCs, they must coordinate their efforts with HSEM, as these large facilities may be eligible to be used as sites for Federal assets such as the Federal Medical Contingency Station (FMCS).
 - Any applicable agency should sign off on the buildings of opportunity declared for use to prevent duplicate sources planning to use the same building.
 - All communities must be prepared for emergencies that exceed the AHR's usual capacity to care for its residents. The Acute Care Center represents one portion of the Modular Emergency Medical System. The ACC is designed as an expandable, modular system that can care for up to 250 patients in increments of 50 per nursing subunit. Ideally, each AHR will be able to identify two separate locations capable of hosting one ACC and one NEHC/POD allowing for simultaneous operation.
- Become meaningfully engaged with planning partners in the AHR through regular communications.
- Recruit human resources for the ACC and NEHC.
 - Refer to Table 4 for suggested staffing requirements.
 - AHRs will be responsible for staffing their own ACC and NEHC with healthcare professionals to the best of their ability. AHRs' MCCs should consider developing or enhancing local Medical Reserve Corps (MRC) units. In the event that an AHR is not able to fully staff their ACC or NEHC, requests could be made for additional staff through the ESAR-VHP system coordinated by HSEM as well as the NNE MMRS New Hampshire Medical Strike Team.
 - Locally, communities must be concerned with identifying the healthcare practitioners available to staff the facility during operation. For some scenarios,

such as pandemic influenza, local communities should address a possible shortage of up to 30%.

- Locate supplies for the ACC and NEHC.
 - AHRs are expected to ensure that appropriate critical equipment and supplies are available to continuously support medical surge for 50 individuals (or 1/1,000 population) within the community for a period of 72 hours. The State will provide significant technical assistance to AHRs and may be able to provide some financial support dependent upon future federal grant funding.

Local communities must ensure the safety of their volunteer staff by providing PPE, food, and security as appropriate.

Hospital Responsibilities

- Hospitals will be expected to support the AHRs to the best of their ability with response efforts at the ACC and the NEHC. Hospitals will have limited, but essential, roles in the development of ACCs and NEHCs.
- Hospitals will participate in AHR working groups as part of the MCCs. Refer to Table 3 to find the corresponding AHR/hospital.

XI. Tier 4 – State

It is almost certain that at this level the Governor will issue, if not done already in the previous stage, an Emergency Declaration for the whole state. In a large scale emergency, it is likely that the healthcare system within any region(s) or all of New Hampshire will be overwhelmed, requiring the rapid forward movement of patients to outpatient healthcare facilities and/or acute care centers in or out of State. As part of preparedness planning, State agencies will facilitate arrangements with AHR's to coordinate response assets. The use of strategic mutual aid and/or cooperative agreements may standardize the implementation of tactical mutual aid between regions and/or towns and promote a cohesive response strategy for bringing health and medical resources to areas of greatest need during a widespread emergency.

State Responsibilities

- NH DHHS will assist the medical sector by providing regulatory relief during emergency response as warranted. Relevant laws or regulations that may need to be revised or temporarily suspended in a public health or medical emergency will be identified during preparedness planning, and processes for their revision or temporary suspension will be formally described. NH DHHS will work with the Legislature during the 2006-2007 legislative session to formalize regulations intended to facilitate this process.
- A unified Area Incident Management team structure for the AHRs will be instituted. See Appendix G
- HSEM, with assistance from the New Hampshire Hospital Association and individual acute-care hospitals, will inventory all hospital beds within New Hampshire and maintain

this data using the WebEOC software platform. The WebEOC tracking system will adhere to the *Hospital Available Beds for Emergencies and Disasters (HAvBED) System* as defined in the AHRQ guidance document (<http://www.ahrq.gov/research/havbed/>).

- NH DHHS will provide all necessary technical assistance, including standardized reporting requirements, to promote uniform reporting of medical, health, and safety issues from affected AHRs.
- For requests that cannot be met by the State, the State EOC will inquire from its regional partners (Tier 5) and / or forward requests for assistance to Federal authorities.

AHR Responsibilities

- Utilizing the National Incident Management System's Incident Command System, AHRs will manage and coordinate information and resources among operational areas.
- AHR health, medical, and safety needs that cannot be met through local resources or tactical mutual aid should be reported to the State EOC. As stated in the NH EOP, HSEM with the support of NH DHHS will rapidly evaluate the requests and attempt to meet them using assets within the State.

Hospital Responsibilities

- Utilizing the National Incident Management System's Incident Command System (NIMS ICS), hospitals will manage and coordinate information and resources among operational areas.
- Hospital health, medical, and safety needs that cannot be met through local resources or tactical mutual aid should be reported to the State EOC. The State will rapidly evaluate the requests and attempt to meet them using assets within the State.

XII. Tier 5 – Interstate

Available Regional Resources, requested by the AHR through the State EOC

- National Guard
 - Civil Support Teams (CSTs)
- Northern New England Metropolitan Medical Response System
 - Medical Strike Team

State Responsibilities

- Interstate coordination. A HRSA Region 1 Medical Surge Workgroup was formed at the New England Pandemic Influenza/Avian Influenza Regional Meeting June 30, 2006 and is in the process of developing a schedule for upcoming meetings. New Hampshire

representatives from DHHS, HSEM, and NHHA are members of the workgroup. Also, a representative of NNE MMRS is a member of the workgroup and will represent Maine, New Hampshire, and Vermont. The workgroup will develop plans to manage coordination between affected states.

- ESAR-VHP

HSEM is responsible for ensuring that the New Hampshire ESAR-VHP system is capable of interfacing with other state ESAR-VHP systems to facilitate the movement of volunteers across state lines.

- Supplies and other resources

- *International Emergency Management Assistance Compact (IEMAC)*

- IEMAC includes the States of Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut and the Provinces of Québec, New Brunswick, Prince Edward Island, Nova Scotia and Newfoundland and Labrador. The purpose of the compact is to provide for the possibility of mutual assistance in managing any emergency when the affected jurisdiction or jurisdictions ask for assistance, whether arising from natural disaster, technological hazard, man-made disaster or civil emergency aspects of resources shortages.
- This compact also provides for the process of planning mechanisms among the agencies responsible and for mutual cooperation, including, if need be, emergency-related exercises, testing, or other training activities using equipment and personnel simulating performance of any aspect of the giving and receiving of aid by party jurisdictions or subdivisions of party jurisdictions during emergencies, with such actions occurring outside actual declared emergency periods. Mutual assistance in this compact may include the use of emergency forces by mutual agreement among party jurisdictions.
- The State EOC is responsible for coordinating the movement of supplies requested through IEMAC across state lines. Additional information about IEMAC can be found at <http://www.iemg-gigu-web.org/>.

AHR / MCC Responsibilities

- Ensure the process is in place to make provisions to request, receive, and integrate additional supplies.

Hospital Responsibilities

- Ensure the process is in place to make provisions to request, receive, and integrate additional supplies.

XIII. Tier 6 – Federal Support to State and AHRs

State Responsibilities

- Requisition and deployment of any federal support (i.e., SNS, DMORT, DMAT) through the State EOC.

AHR / MCC Responsibilities

- Ensure the process is in place to make provisions to request, receive, and integrate Federal resources.

Hospital Responsibilities

- Ensure the process is in place to make provisions to request, receive, and integrate Federal resources.

Staffing

National Disaster Medical System (NDMS)

The National Disaster Medical System is a series of Federal resources controlled by the U.S. Department of Homeland Security (DHS). NDMS is made up of a series of response teams, with some being constructed to treat specific types of patients. Appendix C describes the current construction of NDMS and its available resources. It is expected that Federal NDMS resources will not be immediately available following an emergency. Consequently, the State must plan for self-sufficiency for at least 72 hours.

NDMS resources are requested, with permission from the Governor, from the U.S. Department of Homeland Security by the Commissioner of NH DHHS or his/her designee. The Department of Safety, Homeland Security and Emergency Services is also advised for logistical support services in the reception of these federalized healthcare workers.

Supplies

Federal Medical Contingency Station (FMCS)

The Federal Medical Contingency Station is an effort of the Federal Department of Health and Human Services (HHS) and United States Public Health Service (USPHS) to generate a standardized, scalable surge capacity facility. Similar to the SNS, the FMCS is pre-packaged and ready for immediate deployment by air or land to an existing structure. There are three types of FMCS:

- Type I would provide definitive care, effectively replacing or supplementing an acute care hospital

- Type II would provide specialized services such as isolation, burn care, or critical care
- Type III would provide bed surge for stable, non-complicated patients or special needs individuals. As of June 2006, the FMCS Type III is the only facility ready for deployment.

The FMCS Type III conceptual framework is built around a 250-bed facility made up of 5 pods of 50 beds. The FMCS ships modularly with separate caches of primary care equipment, pharmaceuticals, and beds. Consequently, the DHHS and the USPHS can tailor what ships to a community, based on the need identified at the time of the request.

DHHS and the USPHS expect to staff the FMCS using a combination of Federalized healthcare providers, such as DMAT members or USPHS staff, as well as local individuals. This emphasizes the need for the development of a strong ESAR-VHP system and local response organizations.

A FMCS is requested, with the permission of the Governor, from the Department of Health and Human Services and United States Public Health Service by the Commissioner of NH DHHS or his/her designee. Homeland Security and Emergency Services is also advised for logistical support services in moving and receiving these federal resources.

Strategic National Stockpile (SNS)

The Strategic National Stockpile represents a Federal effort to deliver pharmaceuticals, vaccines, as well as medical supplies and equipment in a rapid fashion to supplement local caches in a time of need. The SNS is a scaleable supply source designed to address both the immediate needs as well as the longer sustainment needs associated with a biological, chemical, or nuclear emergency. A “Push Pack” can be delivered in twelve hours containing medications and supplies vital to the reduction of mortality and morbidity associated with a biological, chemical, or nuclear event. In a protracted emergency, the SNS can also supply pharmaceuticals, supplies, and equipment from the Vendor Managed Inventory (VMI) or by leveraging the purchasing power of the Veterans Administration (VA) system.

The SNS is requested, with permission from the Governor, from the Federal Centers for Disease Control and Prevention (CDC) by the Commissioner of NH DHHS. The Department of Safety, Homeland Security and Emergency Services is also advised for logistical support services during the deployment of the SNS within New Hampshire.

New Hampshire and its local communities should not rely upon the SNS, but rather view it as a means by which to augment existing State and community pharmaceutical caches. There are two major reasons why the SNS should not be relied upon; first, the SNS may not have access to the pharmaceuticals or medical supplies and equipment needed for a given disease. Second, in an extremely large-scale emergency, such as a pandemic, it is entirely possible that the SNS may be exhausted by the time that it is needed within New Hampshire.

Furthermore, it is imperative to realize that the SNS program has focused upon building a stockpile of pharmaceuticals needed for large-scale exposures to biological, chemical, and nuclear events. Consequently, the utility of the SNS is questionable for providing pharmaceuticals for displaced individuals with chronic illnesses in need of medication.

Additional information about the SNS and New Hampshire's preparations for receiving the SNS can be found in Annex #1 of the Health and Medical Services, Emergency Support Function #8, New Hampshire Emergency Operations Plan.

XIV. Plan Maintenance

To be developed after approval.

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State of New Hampshire Public Health Emergency Preparedness and Response Plan, Available at <http://www.dhhs.state.nh.us/DHHS/CDCS/LIBRARY/Policy-Guideline/dphs-health-emergency-plan.htm>

Appendix A – Glossary:

ACC	Acute Care Center
ACF	Alternative Care Facility
AHR	All-hazards Planning Region
AHRQ	Agency for Healthcare Research and Quality
BEM	Bureau of Emergency Management, now called the Department of Safety Homeland Security and Emergency Management
NDMS	National Disaster Medical System
BST	Burn Specialty Team
CBRNE	Chemical, Biological, Radiological/Nuclear and Explosives
CDC	Centers for Disease Control and Prevention, Atlanta GA
CDECC	Communicable Disease Epidemic Control Committee
CRU	Casualty Reception Unit
CST	Civil Support Teams
DHHS	Department of Health and Human Services
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
ECBC	Edgewood Chemical Biological Center
ED	Emergency Department
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Active Labor Act
EOC	Emergency Operations Center
EOP	Emergency Operations Plan

ERI	Epidemic Respiratory Infection
ESAR-VHP	Emergency System for Advanced Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
FMCS	Federal Medical Contingency Station
GER	Global Emergency Resources
GIS	Geographic Information Systems
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources Services Administration
HSA	Hospital Service Area
HSEEP	Homeland Security Exercise and Evaluation Program
HSEM	Department of Safety Homeland Security and Emergency Management
HVA	Hazards Vulnerability Assessment
IEMAC	International Emergency Management Assistance Compact
ILI	Influenza-like Illness
IMSuRT	International Medical/Surgical Team
JAS	Job Action Sheet
MCC	Medical Command and Control
MEMS	Modular Emergency Medical System
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MSA	Metropolitan Statistical Area
MSCC	Medical Surge Capacity and Capability

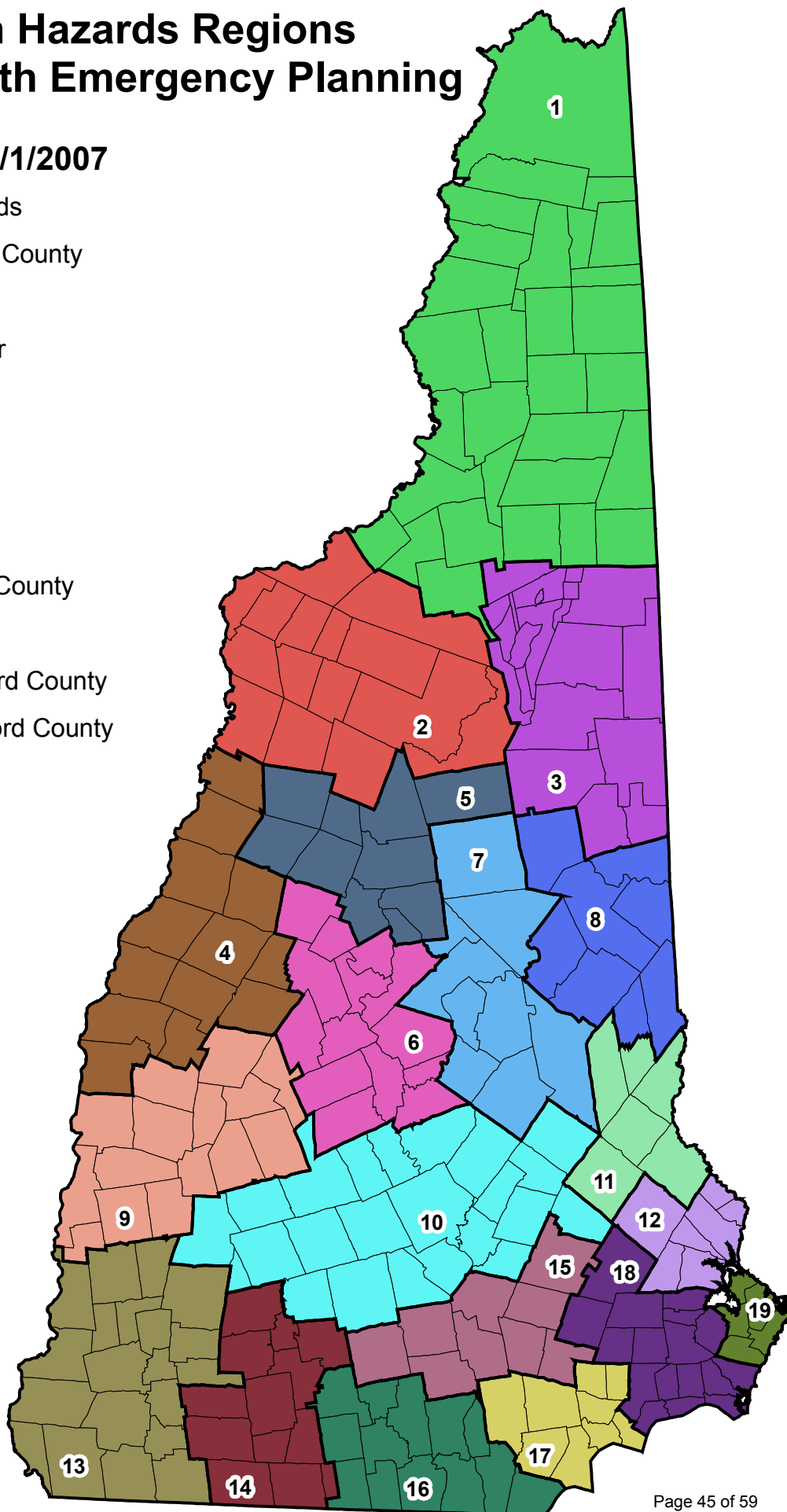
MST	Management Support Team; Medical Strike Team
NECEP	England Center for Emergency Preparedness
NEHC	Neighborhood Emergency Health Center
NGO	Non-governmental Organizations
NH DHHS	New Hampshire Department of Health and Human Services
NH EOP	New Hampshire Emergency Operations Plan
NHHA	New Hampshire Hospital Association
NHHSEM	New Hampshire Homeland Security and Emergency Management (formerly Bureau of Emergency Management or BEM)
NIMS	National Incident Management System
NNE MMRS	Northern New England Metropolitan Medical Response System
NNRT	National Nurse Response Teams
NP	Nurse Practitioner
NPRT	National Pharmacist Response Teams
NRP	National Response Plan
OEM	Office of Emergency Management
OSHA	Occupational Safety and Health Administration
PAPR	Powered Air Purifying Respirators
PA	Physician's Assistant
PCC	Patient Control Center
PCR	Polymerase chain reaction
POD	Points of Dispensing
PPCC	Pandemic Planning Coordinating Committee
PPE	Personal Protection Equipment

PST	Pediatric Specialty Team
RMBT	Rocky Mountain Bioterrorism Working Group
RRS	Regional Response System
SBCCOM	U.S. Army Soldier and Biological Chemical Command
SNS	Strategic National Stockpile
TCL	Target Capabilities List
TRB	Transportation Research Board
UASI	Urban Area Security Initiative
USPHS	United States Public Health Service
VA	Veteran's Administration
VMAT	Veterinary Medical Assistance Teams
VMI	Vendor Managed Inventory

All Health Hazards Regions for Public Health Emergency Planning

Planning Regions 1/1/2007

- 1-Great North Woods
- 2-Northern Grafton County
- 3-Northern Carroll
- 4-Lebanon/Hanover
- 5-Plymouth
- 6-Bristol/Franklin
- 7-Laconia/Meredith
- 8-Southern Carroll
- 9-Greater Sullivan County
- 10-Concord
- 11-Northern Strafford County
- 12-Southern Strafford County
- 13-Keene
- 14-Peterborough
- 15-Manchester
- 16-Nashua
- 17-Southeastern
- 18-Exeter
- 19-Portsmouth



Appendix C – Federal NDMS Assets:

Table C-1. Available National Disaster Medical System (NDMS) resources as of October 20, 2005.

Team	#	FEMA Typed Resource Definition (May 2005)
Burn Specialty Team (BST)	5	A BST is a volunteer group of medical and nonmedical individuals, usually from the same state or region of a state, that have formed a response team under the guidance of the National Disaster Medical System (or state or local auspices), and whose personnel have specific training/skills in the management of burn trauma patients.
Crush Injury Specialty Team	1	A Crush Injury Specialty Team is a volunteer group of medical and nonmedical individuals, usually from the same State or region of a State, who have formed a response team under the guidance of the National Disaster Medical System (or State or local auspices), and whose personnel have specific training/skills in the management of crush injury patients.
Disaster Medical Assistance Team (DMAT)	55*	A DMAT is a volunteer group of medical and nonmedical individuals, usually from the same State or region of a State, who have formed a response team under the guidance of the National Disaster Medical System, or under similar State or local auspices. A standard DMAT deploys with 35 personnel for all missions. Personnel include a mix of physicians, nurses (RN), nurse practitioners (NP), physicians' assistants (PA), pharmacists (RPh), emergency medical technicians (EMT), other allied health professionals, and support staff.
Disaster Mortuary Operational Response Team (DMORT)	11	A DMORT is a volunteer group of medical and forensic personnel, usually from the same geographic region, who have formed a response team under the guidance of the National Disaster Medical System (or State or local auspices), and whose personnel have specific training/skills in victim identification, mortuary services, and forensic pathology and anthropology methods. A standard DMORT deploys with 31 personnel plus basic load of equipment. Usually includes a mix of medical examiners, coroners, pathologists, forensic anthropologists, medical records technicians, fingerprint technicians, forensic odontologists, dental assistants, radiologists, funeral directors, mental health professionals, and support personnel.
International Medical / Surgical Teams (IMSuRT)	3**	An IMSuRT team is a volunteer group of medical and nonmedical individuals, usually from the same State or region of a State, that have formed a response team under the guidance of the National Disaster Medical System and the State Department, and whose personnel and equipment give it deployable medical and surgical treatment capability, worldwide. A full IMSuRT team consists of roughly 26 personnel. This is the only NDMS medical team with surgical OR capability.
Management Support Team (MST)	1	An MST is a command and control team that provides support and liaison functions for other NDMS teams in the field.
Mental Health Specialty Teams	3	A Mental Health Specialty Team is a volunteer group of medical and nonmedical individuals, usually from the same State or region of a State, who have formed a response team under the guidance of the National Disaster Medical System (or State or local auspices), and whose personnel have specific training/skills in the management of psychiatric patients.
National Medical Response Teams for Weapons of Mass Destruction	4	Specially trained and equipped DMATs that can rapidly respond to a WMD event and provide decontamination and treatment of victims and responders.
National Nurse Response Teams (NNRT)	10	The NNRT is a specialty DMAT that will be used in any scenario requiring hundreds of nurses to assist in chemoprophylaxis, a mass vaccination program, or a scenario that overwhelms the nation's supply of nurses in responding to a weapon of mass destruction event.
National Pharmacist Response Teams (NPRT)	10	The NPRT is a specialty DMAT that will be used to assist in chemoprophylaxis or the vaccination of hundreds of thousands, or even millions of Americans, or perhaps in another scenario requiring hundreds of pharmacists, pharmacy technicians, and students of pharmacy.
Pediatric Specialty Team (PST)	2	A PST is a volunteer group of medical and nonmedical individuals, usually from the same State or region of a State, who have formed a response team under the guidance of the National Disaster Medical System (or State or local auspices), and whose personnel have specific training/skills in the management of pediatric patients.
Veterinary Medical Assistance Teams (VMAT)	3	A VMAT is a volunteer team of veterinarians, technicians, and support personnel, usually from the same region, who have organized a response team under the guidance of the American Veterinary Medical Association and the NDMS, and whose personnel have specific training in responding to animal casualties and/or animal disease outbreaks during a disaster. A VMAT deploys with 60 personnel plus equipment. Usually includes a mix of veterinarians, veterinary technicians, support personnel, microbiologists, epidemiologists, and veterinary pathologists.
* 22 DMATs fully operational, 33 classified as augmentation or developmental.		
** 2 IMSuRT fully operational, 1 classified as developmental.		

Appendix D –MSCC in Pandemic Influenza

Special Considerations for Acute Care Center Implementation during Pandemic Influenza

The threat of influenza pandemic poses some unique challenges. The rapidly widespread and prolonged natures of a respiratory pandemic are the two most problematic aspects for planning purposes. Community self-reliance will be critical. In a pandemic, provided there are adequate portable, medical oxygen supplies, both the NEHC and ACC could serve as centers focused exclusively on the care of influenza patients. However, it may be that the best use of such a center would be for non-influenza patients such as those persons displaced from nursing homes in an attempt to free space for more acutely ill overflow patients or those persons displaced from hospice.

Pandemic Modeling/Scenarios

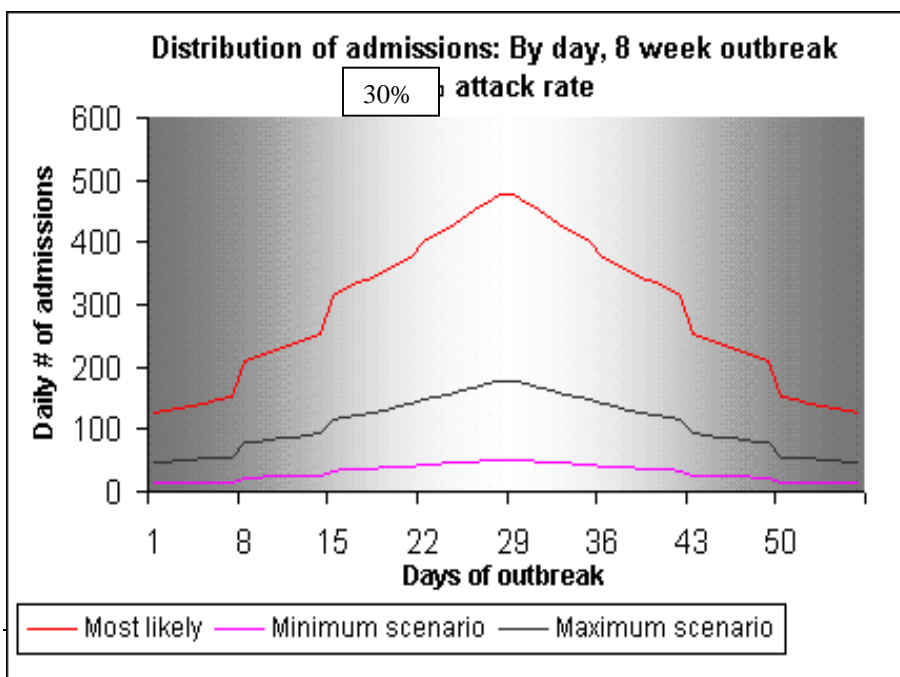
State pandemic influenza planners met at the New England Pandemic Influenza/Avian Influenza Regional Meeting and discussed healthcare surge capacity. At this meeting a consensus was reached between the New England States and New York to plan for healthcare surge capacity for pandemic influenza by applying the same assumptions to their respective state populations. A 30% attack rate, duration of 8 weeks, 4% hospitalization rate, and a 1% death rate were agreed upon. The data-populating Table D-1 was obtained from the Centers for Control and Prevention Flu Surge 2.0 software. The New England Region adopted the strategy to plan healthcare surge based upon the numbers generated by the Flu Surge 2.0 Software for the peak week of the pandemic wave.

State specific data inserted into the Flu Surge 2.0 Software includes:

- The average number of staffed, licensed non-ICU beds is 76%.
- The average number of staffed, licensed ICU beds in the State is assumed to be 90%.
- The number of ventilators available is assumed to be 100%.

Table D-1. Pandemic Planning Scenario for New Hampshire

State of New Hampshire Population:	1,344,153
<i>Hospital Capacities</i>	
Staffed Non-ICU Beds:	2,149
Staffed ICU Beds:	374
Total Hospital Surge Capacity:	30% increase in hospital beds made available by surge strategies within the hospital = 3,280 beds
Ventilators:	246
Staffed ICU Bed/Ventilator:	1.5
<i>Capacity to be built in the 19 all Hazard Planning Regions</i>	
<i>*1 ACS bed / 1,000 population if the population in the region exceeds 50,000</i>	800
<i>*1-50 Bed ACS Unit per region if the population is less than 50,000</i>	700
Total Community Surge capacity	1500
<i>Planning Assumptions</i>	
Duration of Wave	8 Weeks
Attack Rate	30% = 403,246
Hospitalization Rate	4% = 16,130
Death Rate	1% = 4,032
<i>Flu Surge Projections at the Peak Week</i>	
Inpatients	2,333
Daily Admissions	478
Deaths (in hospital)	766 (536)



Total Hospital Admissions (most likely)	16,130
Total Deaths (most likely)	4,032

Appendix E

TITLE LII ACTIONS, PROCESS, AND SERVICE OF PROCESS

CHAPTER 508 LIMITATION OF ACTIONS

Section 508:17-a

508:17-a Agents Assisting Certain State Departments; Liability Limited. –

I. Any person who acts as an agent to the department of health and human services or the department of safety by providing assistance in response to a specific public health or public safety incident shall be protected from claims and civil actions arising from acts committed within the scope of his or her official duty as an agent to such departments to the same extent as state officers, trustees, officials, employees, and members of the general court under RSA 99-D, provided that:

- (a) The commissioner of the department of health and human services or the commissioner of the department of safety has declared in writing to the governor that a public health or public safety incident exists;
- (b) The department of health and human services or the department of safety has designated the person to act as its agent to assist in responding to the public health or public safety incident;
- (c) The agent was acting in good faith and within the scope of his or her official functions and duties as an agent to the department of health and human services or the department of safety; and
- (d) The damage or injury was not caused by willful, wanton, or grossly negligent misconduct by the agent.

II. In this section:

- (a) "Agent" means any person who acts as an agent to the department of health and human services or the department of safety by providing assistance in response to a specific public health or public safety incident and the person does not receive compensation from either department, other than possible reimbursement for expenses actually incurred for such services, but who may be receiving compensation from his or her employer or from any other source.
- (b) "Damage or injury" includes physical, nonphysical, economic and noneconomic damage, and property damage.
- (c) "Public health or public safety incident" means a specific incident that the commissioner of the department of health and human services or the commissioner of the department of safety has declared in writing poses a threat to the health and safety of the public and demands a response that will require the assistance of agents from outside the state system, but which does not rise to the level that would necessitate the declaration of a state of emergency by the governor under RSA 4:45.

III. Notwithstanding any other provision of law, no person shall be considered an agent of the department of health and human services or the department of safety for the purposes of this section unless the commissioner of one of those 2 departments has declared in writing to the governor that a public health or public safety incident exists and the appropriate department acknowledges in writing the person's status as an agent. Such written acknowledgment shall identify the person, indicate the department of the state for which the person will be acting as an

agent, indicate the duration for which the person will be acting as an agent, indicate the functions that the person will be performing for the appropriate department, and specifically indicate that the provisions of this section apply to the person's status as an agent to the appropriate department.

IV. Any licensed health care provider who acts as an agent to the department of Health and Human Services by providing health care or services in response to a public health incident shall work under the oversight of a department physician.

V. No disciplinary action shall be taken by a licensing board against a licensed health care provider who acted as an agent or a volunteer to the department of Health and Human Services or the department of safety. This paragraph shall apply only to a health care provider who was designated by either the department of health and human services or the department of safety to act as an agent in accordance with paragraph III and who acted in good faith within the scope of his or her official functions and duties as an agent, and who did not engage in willful, wanton, or grossly negligent conduct in the course of carrying out his or her official functions and duties.

Source. 2005, 191:5, eff. Jan. 1, 2006.

HB 618 FACT SHEET

During the last legislative session the House and Senate passed, and the Governor signed, HB 618. HB 618 did several things. First it created a new statutory provision, RSA 508:17-a. This statutory provision authorizes the Commissioner of the Department of Health and Human Services or the Commissioner of the Department of Safety to declare a public health or public safety incident. Under that statute “public health or public safety incident” is defined as:

“A specific incident that the commissioner of the department of health and human services or the commissioner of the department of safety has declared in writing poses a threat to the health and safety of the public and demands a response that will require the assistance of agents from outside the state system, but which does not rise to the level that would necessitate the declaration of a state of emergency by the governor under RSA 4:45.”

RSA 508:17-a further allows the two Commissioners to seek the assistance of agents to assist in response to the specific public health or public safety incident. Under the statute “agent is defined as:

“Any person who acts as an agent to the department of health and human services or the department of safety by providing assistance in response to a specific public health or public safety incident and the person does not receive compensation from either department, other than possible reimbursement for expenses actually incurred for such services, but who may be receiving compensation from his or her employer or from any other source.”

Under RSA 508:17-a, any person who acts as an agent to the department of health and human services or the department of safety by providing assistance in response to a specific public health or public safety incident will be protected from claims and civil actions arising from acts committed within the scope of his or her official duty as an agent to such departments to the same extent as state officers, trustees, officials, employees, and members of the general court under RSA 99-D. This protection from liability will only be in affect when:

- One of the two Commissioners identified above has declared in writing that a public health or public safety incident exists;
- Either DHHS or DOS has specifically designated the person in writing to act as its agent to assist in responding to the public health or public safety incident;
- The agent was acting in good faith and within the scope of his or her official functions and duties as an agent to the department of health and human services or the department of safety; and
- The damage or injury was not caused by willful, wanton, or grossly negligent misconduct by the agent.

In addition, under RSA 508:17-a, no disciplinary action may be taken by a licensing board against a licensee who acts as an agent in accordance with the provisions set forth above so long

as the licensee acted within the scope of his or her official functions and duties as an agent and so long as the licensee did not engage in conduct that was willful, wanton, or grossly negligent.

HB 618 also amended the workers' compensation statute (RSA 281-A) to clarify that if a person is injured while acting as an agent in accordance with the provisions set forth in RSA 508:17-a, the State of New Hampshire and not the agent's regular employer will bear the cost of workers' compensation. In effect, the agent will be considered an employee of the State of New Hampshire for the purposes of workers' compensation.

HB 618 took effect on January 1, 2006.

Appendix F

HIPAA Privacy During an Emergency

Can health care information be shared in a severe disaster?

Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all of the following ways:

TREATMENT:

Health care providers can share patient information as necessary to provide treatment.

Treatment Includes:

- Sharing information with other providers (including hospitals and clinics),
- Referring patients for treatment (including linking patients with available providers in areas where the patients have relocated), and coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate health services). Providers can also share patient information to the extent necessary to seek payment for these health care services.

NOTIFICATION:

Health care providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death. The health care provider should get verbal permission from individuals, when possible; but if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest. Thus, when necessary, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify, or otherwise notify family members and others as to the location and general condition of their loved ones.

In addition, when a health care provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

IMMINENT DANGER:

Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public -- consistent with applicable law and the provider's standards of ethical conduct.

FACILITY DIRECTORY:

Health care facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

Of course, the HIPAA Privacy Rule does not apply to disclosures if they are not made by entities covered by the Privacy Rule. Thus, for instance, the HIPAA Privacy Rule does not restrict the American Red Cross from sharing patient information.

Reference:

United States Department of Health and Human Services

<http://www.hhs.gov/ocr/hipaa/emergencyPPR.html>. Retrieved 9/1/2006.

Appendix G

Public Health Regional Resource Coordination Center (RRCC)

Purpose: To provide a regional center to coordinate local resources that regions may wish to pool or disseminate during a large-scale public health emergency.

When to Activate: Regional Resource Coordination Centers should be activated when there is a large-scale, public health situations that demand an “Area Command” incident command structure as outlined in the National Incident Management System. Such an event usually involves a public health issue that is not site specific, is geographically dispersed, and evolves over time. It often also necessitates the management of multiple incidents across jurisdictional boundaries. This activation will be started under two scenarios:

- If the Commissioner of NH DHHS, declares a local, regional or Statewide Public Health Incident
- In response to a recommendation from the NH DHHS, through the EOC, when the Governor has issued a regional or Statewide emergency declaration

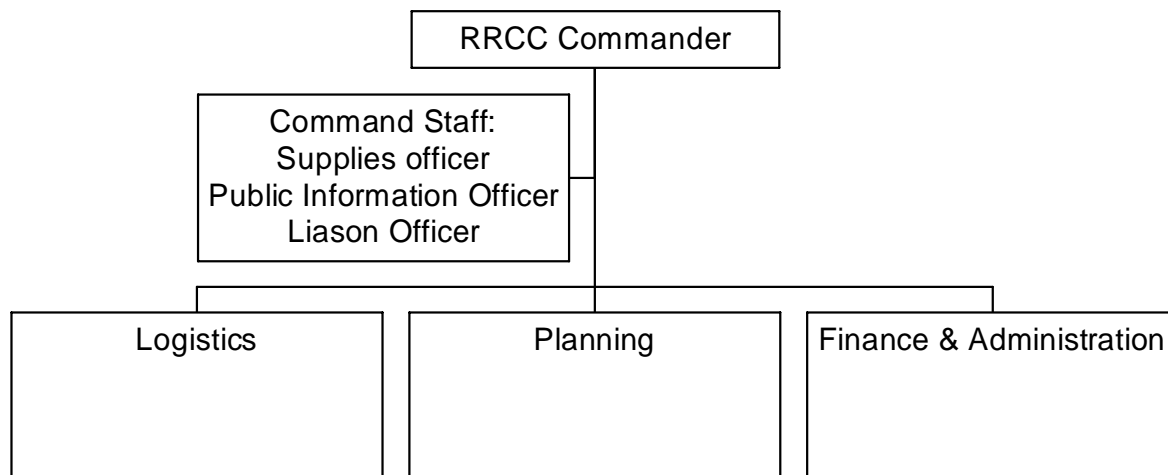
Definitions:

- Modular Emergency Medical System (MEMS) Facility: this guidance will designate any large-scale response center, including but not limited to a Point of Dispensing (POD), Acute Care Center (ACC), or Mass Care Shelter as a MEMS facility.

Location: If possible, All-Hazards Region (AHR) planners should designate a central location in the region that is also equipped well enough to serve as an RRCC. Some equipment that may be considered for this purpose includes, but is not limited to:

- Standard Equipment: Computer, LCD projector, overhead projector, white board, easel with flip charts, tables, chairs, screen
- IT: phone jacks, data ports, outlets connected to emergency generator, several other electrical outlets, wireless internet

RRCC Structure:



Responsibilities

The following responsibilities are to serve as a guide for designating tasks and are not all encompassing. More detailed job action sheets should be provided to members of the RRCC upon activation. AHR planners may wish to develop such job action sheets as a part of their planning efforts.

- **RRCC Commander:** Sets the incident objectives, strategies, and priorities and has overall responsibility at the incident or event. In addition to having overall responsibility for managing the entire incident, the Incident Commander is specifically responsible for:
 - Ensuring incident safety.
 - Providing information services to internal and external stakeholders.
 - Establishing and maintaining liaison with other agencies participating in the incident.
- **Public Information Officer (PIO):** Serves as the conduit for information to internal and external stakeholders, including the media or other organizations seeking information directly from the incident or event. Obtains information from State EOC and/or ESF-8 and provides information to general public and media

Liaison Officer (LNO): Serves as the primary contact for supporting agencies assisting at an incident, including hospitals.

Operations Section: The RRCC follows an Area Command incident command structure in which the Operations Section is not activated since tactical operations are being conducted on-scene at the incident or MEMS facilities. For example, operations will be conducted at Points of Dispensing (PODs), Mass Care / Shelters, and Acute Care Centers (ACCs), all of which will have their own, on-scene Operations Section. The actual operations will take their tactical operational guidance regarding health and medical issues from the ESF-8 coordinator at the State level or NH DHHS Incident Command Center (ICC).

Logistics Section: Provides support, resources, and all other services needed to meet the operational objectives.

- Provides resources and services required to support incident activities including but not limited to
 - Clinic supplies and general resources
 - Support for staff (e.g., food, breaks, training)
 - IT/Communications equipment
 - Security (e.g., area security, traffic, access control and security for SNS assets)
 - Transportation (e.g., SNS, medical supplies, staff)
 - Staffing

Planning Section: Prepares and documents the Incident Action Plan to accomplish the objectives, collects and evaluates information, maintains resource status, and maintains documentation for incident records.

- Main point of contact to MEMS Facility

Finance and Administration Section: Monitors costs related to the incident. Provides accounting, procurement, time recording, and cost analyses

Communications Issues

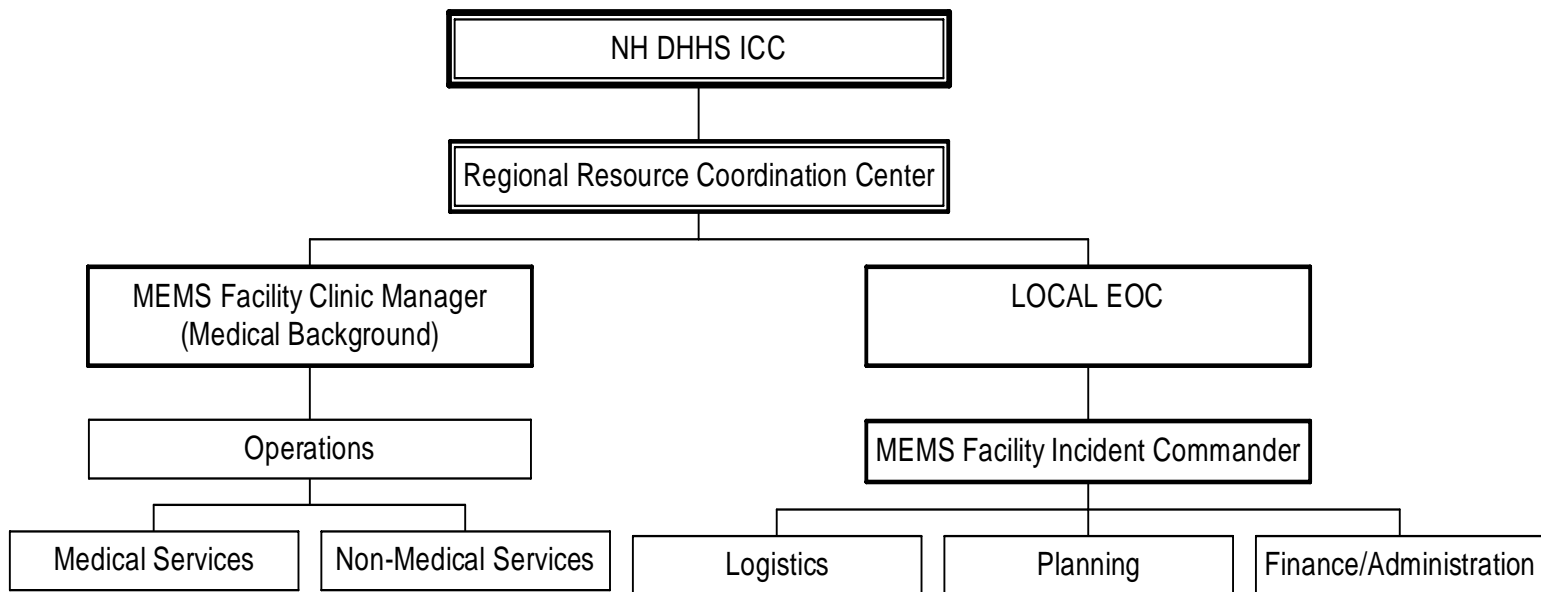
- Safety and Security
 - MEMS Facility Incident Commander will contact Local EOC for Safety and Security needs
 - Local EOC will use existing Mutual Aid with area Police Departments to fulfill requests
 - Local EOC will contact RRCC for any request unable to be fulfilled; will also provide periodic updates to RRCC. RRCC will then communicate to State EOC any needs unable to be fulfilled on a regional level
- Staff and Supplies
 - MEMS Facility Clinic Manager will contact RRCC with staffing and supply needs
 - All requests will be received by Planning Chief and disseminated to appropriate branch
 - RRCC will contact State EOC for any request unable to be fulfilled

Staffing The RRCC

The number of individuals required to staff the RRCC (approximately 2-5 individuals) will be emergency specific, but should always consider an appropriate and manageable span of control, as is described in the National Incident Management System (NIMS). The number of shifts per day and the duration of the RRCC activation will be determined by the incident.

Each municipality in the region should be asked to designate one person who could staff the RRCC. The representatives should not be people that may likely need to serve in their own local EOC's, and they should be individuals who are able to fulfill the requirements listed on the job action sheet developed by AHR planners. Each identified representative should be meet federal NIMS Certification requirements, with successful completion of courses on NIMS and ICS. Online training is available through the Federal Emergency Management Agency (<http://www.training.fema.gov/>). It is strongly recommended that trained individuals also attend several drills to exercise the RRCC model.

MEMS Facility to NH DHHS ICC Command Structure



Funding of the RRCC

Funds to procure equipment and other materials needed to set up an RRCC would be an allowable expense using funds provided for All-Hazards Region planning. The funding mechanism necessary to allow the RRCC to fulfill its function of procuring supplies for MEMS facilities should be considered during the AHR planning process. Representatives of municipal governments could enter into Memoranda of Agreement with the agency hosting the RRCC to describe how state or federal disaster funds provided to municipalities could be equitably allocated to support RRCC functions.